| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155834 | A. BUILDING -- B. WING | 04/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET INDIANAPOLIS, IN 46260 |

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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: 04/11/23<br><br>Facility Number: 013738<br>Provider Number: 155834<br>AIM Number: 100272170<br><br>At this Emergency Preparedness survey, Brickyard Healthcare - Willow Springs 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 134 certified beds. At the time of the survey, the census was 71.<br><br>Quality Review completed on 04/13/23 | E 0000 | | |
| 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: 04/11/23<br><br>Facility Number: 013738<br>Provider Number: 155834<br>AIM Number: 100272170<br><br>At this Life Safety Code survey, Brickyard | K 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Sonia Patel | Executive Director | 04/27/2023 |

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 - Willow Springs Care Center was found not 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 three-story facility with a basement was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 134 and had a census of 71 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review completed on 04/13/23 | | | |
| K 0100 SS=E Bldg. 01 | NFPA 101<br>General Requirements - Other<br>General Requirements - Other<br>List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on observation and interview, the facility failed to ensure 1 of 3 corridor door sets on the second floor would self close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public | K 0100 | Preparation or excecution of the Plan of Correction does not constitute admission or agreement or conclusion set forth on the statement of deficiencies. The | 05/01/2023 |

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| | if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by Room 216 on the second floor.<br><br>Findings include:<br><br>Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the east door in the corridor door set by Room 216 was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Director of Maintenance agreed the east door in the corridor door set by Room 216 would not fully self close and latch into the door frame.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | Plan of Correction is prepared and excecuted solely because it is required by the position of Federal and State law. The Plan of Correction is submitted to respond to allegations of non compliance cited. Please accept this Plan of Correction as the provider's credible allegation of compliance. The provider respectfully requests desk review and paper compliance to be considered in establishing that the provider is in compliance.<br><br>1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- The corridor doors to the east side by room 216 has beed repaired to latch into the door frame.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by room 216 on the second floor. All self closing doors with latches which is connected to the fire alarm system activation has been checked to ensure all devices are latching.<br><br>3. What measures will be put in | |

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| | | | place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Director/designee has completed an audit of all door with latching hardware to ensure that devices self close and latch into the door frame. This will be monitored daily during maintenance checks and will be ongoing.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Results of the daily audits will be submitted monthly to the Quality Assurance Committee<br><br>5. Date of Compliance.<br>- 5-1-23 | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that | | | |

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| | do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322) | | | |
| | Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous areas such as trash collection rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the trash collection room in the basement across from the elevator machine room.<br><br>Findings include:<br><br>Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the latching mechanism for the corridor door to the trash collection room in the basement across from the elevator machine room was removed which prevented the door from latching into the door | K 0321 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- The latching mechanism on the door to the trash collection room in the basement has been replaced with a new latching device allowing the door to now latch into the door frame and replaced the keypad lock.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- The deficient practice could affect over 5 residents, staff and visitors in the vicinity of the trash | 05/01/2023 |

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| | frame. The door was equipped with a self closing device. The room contained three cardboard boxes filled with biohazard waste. Based on interview at the time of the observations, the Director of Maintenance agreed the latching mechanism was removed from the door which prevented the door from self closing and latching into the door frame.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | collection room in the basement.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenace Director/designee has audited all self closing door devices for complaince. Maintenance Director/designee will monitor all self closing doors during regular weekly PM.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Maintenance director/designee will audit weekly and submit results to the monthly Quality Assurance Committee<br><br>5. Date of Compliance. | |
| K 0324<br>SS=D<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer | | | |

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| | patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br>Based on record review, observation and interview; the facility failed to ensure repair documentation was available for review to ensure 1 of 1 kitchen range hood fire suppression systems and 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition:<br>(1) Cooking equipment<br>(2) Hoods<br>(3) Ducts (if applicable)<br>(4) Fans<br>(5) Fire-extinguishing equipment<br>(6) Special effluent or energy control equipment<br>Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. This deficient practice could affect over two kitchen staff.<br><br>Findings include:<br><br>a. Based on review of the kitchen range hood fire suppression system inspection contractor's "Kitchen Suppression System Inspection" documentation dated 10/17/22 with the Executive | K 0324 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- Service for kitchen range hood fire supression system and kitchen range hood exhaust system has been completed and maintained for proper working order.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- this deficient practice to affect over 2 kitchen staff.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Director/designee will monitor all timely services and review for appropriate documentation and complete all recommendations as needed. | 05/01/2023 |

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| | Director and the Director of Maintenance during record review from 9:45 a.m. to 12:15 p.m. on 04/11/23, deficiencies were noted with the kitchen range hood fire suppression system. The "Remarks/Comments" section of the 10/17/22 inspection report stated "Tilt skillet needs to shut off on system trip and exhaust. Fan needs to turn on regardless of manual operation of devices. Wires need to be run outside of the Ansul Automan. Maintenance requested service call for above deficiencies". Based on interview at the time of record review, the Director of Maintenance stated he was not aware if the deficiencies noted during the 10/17/22 inspection were corrected and agreed repair documentation on or after 10/17/22 was not available for review at the time of the survey.<br><br>b. Based on review of the kitchen range hood exhaust system inspection contractor's "Job Service Report" documentation dated 07/05/22 and 03/31/23 with the Executive Director and the Director of Maintenance during record review from 9:45 a.m. to 12:15 p.m. on 04/11/23, deficiencies were noted with the kitchen range exhaust system. The 07/05/22 and 03/31/23 inspection reports each stated the exhaust fan was not working. Based on interview at the time of record review, the Director of Maintenance stated he was not aware if the deficiencies noted during the 07/05/22 and 03/31/23 were corrected and agreed repair documentation on or after 03/31/23 was not available for review at the time of the survey. Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the kitchen range hood fan appeared to be in operation.<br><br>This finding was reviewed with the Executive | | 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Director of Maintenance/designee will maintain scheduled services and documentation as needed and report results to the monthly Quality Assurance Committee.<br><br>5. Date of Compliance.<br>- 5-1-23 | |

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| | Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | | |
| K 0345 SS=C Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the date and the time of day for the main fire alarm control panel located on the first floor in the storage room by Room 123 was incorrect. The display read the date as 5/20 and the time of day as 12:36 p.m. at 2:06 p.m. The date and the time of day for the remote fire panel located at the third floor nurse's station was also incorrect. The display for the remote fire alarm panel read the date as 5/20 and | K 0345 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- The Fire Alarm Control Panel located on the first floor in the storage room by room 123 has been corrected with accurate time and date information.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- This deficient practice could affect all residents, staff and visitors.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the | 05/01/2023 |

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| | the time of day as 11:23 a.m. at 12:54 p.m. Based on interview at the time of the observations, the Director of Maintenance agreed the main fire alarm control panel and the remote fire alarm panel did not display the correct date and the correct time of day.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | deficient practice does not recur.<br>- Maintenance Director/designee will monitor during daily rounds to ensure correct date and time is maintained.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Maintenance/designee will take appropriate measure to maintain the fire alarm system to assure that it has accurate time and date information in accordance with the requirements of NFPA. All results will be submitted to the monthly Quality Assurance Coommittee.<br><br>5. Date of Compliance.<br>- 5-1-23 | |
| K 0353<br>SS=E<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source | | | |

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| | Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on observation and interview, the facility failed to ensure 2 of over 100 sprinkler heads in the facility were free of paint in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced:<br>(1) Leakage<br>(2) Corrosion<br>(3) Physical Damage<br>(4) Loss of fluid in the glass bulb heat responsive element<br>(5) Loading<br>(6) Painting unless painted by the sprinkler manufacturer.<br>In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler.<br>This deficient practice could affect over 20 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the sprinkler installed on the ceiling in the linen closet by Room 220 and installed on the ceiling in the clean linen | K 0353 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- The sprinkler in the ceiling in the linen closet by room 220 and the linen closet by room 232 has been replace that were covered with white paint.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- The deficient practice could affect over 20 resident, staff and visitors. An audit of all sprikler heads in the facility has been completed to ensure non are covered in paint.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Dirctor/designee will ensure to assess that no paint is covering the sprinkler heads after any painting or repair conducted in the facility.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, | 05/01/2023 |

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| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET<br>INDIANAPOLIS, IN 46260 |

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| | closet by Room 232 were covered with white paint. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned automatic sprinkler locations were painted.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | i.e., what quality assurance program will be put into place.<br>- Miantenace Director will check sprinkler heads during weekly PM and report results to the monthly Quality Assurance Committee.<br><br>5. Date of Compliance.<br>- 5-1-23 | |
| K 0355 SS=E Bldg. 01 | NFPA 101<br>Portable Fire Extinguishers<br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>Based on observation and interview, the facility failed to ensure 3 of 23 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 5 residents, staff and visitors in the basement. | K 0355 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- 2 of the 2 wall mounted fire extinguishers in the maintenance office and the 1 wall mounted fire extibguisher in the central supply room in the basement have been serviced and updated with the current service date.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- This deficient practive could affect 5 residents, staff and visitors inthe basement. An audit of all fire | 05/01/2023 |

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| | Findings include:<br><br>Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, two of two wall mounted ABC type portable fire extinguishers located in the Maintenance Office in the basement each had an affixed maintenance tag by an inspection contractor indicating the date the most recent annual maintenance was performed was more than one year ago. The maintenance tag on the fire extinguisher nearest the corridor door had a maintenance tag indicating the most recent annual maintenance was performed in April 2018. The maintenance tag on the fire extinguisher above the work bench in the room indicated the most recent annual maintenance was performed in April 2021. In addition, the wall mounted ABC type portable fire extinguisher located in the Central Supply Room in the basement had an affixed maintenance tag by an inspection contractor indicating the date the most recent annual maintenance was performed in April 2021. Based on interview at the time of the observations, the Director of Maintenance agreed it had been greater than twelve months since the most recent annual maintenance was documented on the aforementioned three portable fire extinguishers.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | extinguishers in the faciity has been completed.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Director/designee will maintain a log of all fire extinguishers in the facility and ensure that all fire extinguishers are checked during annual service<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Maintenance Director/designee will log all fire extinguishers monthly for compliance. All results will be submitted monthly to the Quality Assurance Committee<br><br>5. Date of Compliance.<br>- 5-1-23 | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors | | | |

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| | 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.<br>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, 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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | | | |

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| | Based on observation and interview, the facility failed to ensure 2 of over 75 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors on the second and third floor.<br><br>Findings include:<br><br>Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the corridor door to resident sleeping Room 234 and the corridor door to resident sleeping Room 318 on the third floor each failed to latch into the door frame when tested to close multiple times. The latching mechanism on each door would not protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned two corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | K 0363 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- The latching mechanismn to the corridor door to resident room 234 on the second floor and the corridor door to resident room 318 on the third floor has been replaced for the door to latch into the door frame.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- The deficient practice could affect over 20 residents, staff and visitors on the second and third floor. An audit of all corridor doors have been completed.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Director/designee will maintain a log for checking all corridor doors for compliance.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Maintenance Director/designee will monitor corridor doors during daily rounds to ensure all doors | 05/01/2023 |

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| | | | are latching into the door frame. All results will be submitted monthly to the Quality Assurance Committee.<br><br>5. Date of Compliance.<br>- 5-1-23 | |
| K 0372 SS=F Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS. | | | |
| | Based on observation and interview, the facility failed to ensure 4 of 9 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 50 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Director of | K 0372 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- a. The 2 inch in diameter hole in the ceiling above the corridor door by room A111 on the first floor has been repaired with fire rated chaulking.<br>b. The 3 inch in diameter hole in the ceiling above the corridor door by room A229 on the second floor has been repaired | 05/01/2023 |

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| | Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the following was noted:<br>a. a two inch in diameter hole for the passage of an electrical conduit was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room A111 on the first floor.<br>b. a three inch in diameter hole was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room A229 on the second floor.<br>c. a three inch in diameter hole for the passage of three data cables and an open ended conduit was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room A314 on the third floor. In addition, a four inch by four inch hole was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room A328 on the third floor.<br>Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned openings in smoke barrier walls were not firestopped to maintain the fire resistance rating of the smoke barrier wall.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | with fire rated chaulking.<br>c. The 3 inch in diameter hole above the corridor door by room A314 and A328 on the third floor has been repaired with fire rated chaulking.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- This deficient practice could affect over 50 residents, staff and visitors. An audit has been completed to ensure there is no holes or openings and maintain the fire resistance rating of the smoke barrier wall.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Director/designee will ensure to assess for any holes or openings after any maintenance or repair work conducted in the facility.<br><br>4. How thw corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Maintenance Director/designee will monitor during daily rounds for any descrepancies and report results to the monthly Quality Assurance Committee. | |

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| | | | 5. Date of Compliance.<br>- 5-1-23 | |
| K 0541<br>SS=E<br>Bldg. 01 | NFPA 101<br>Rubbish Chutes, Incinerators, and Laundry Chu<br>Rubbish Chutes, Incinerators, and Laundry Chutes<br>2012 EXISTING<br>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.<br>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)<br>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.<br>19.5.4, 9.5, 8.4, NFPA 82<br>Based on observation and interview, the facility failed to maintain 1 of 1 laundry chutes in accordance with NFPA 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment. LSC 9.5.2 requires | K 0541 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- The latching mechanism for the | 05/02/2023 |

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| | laundry chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.3.3.1.1 and Section 5.2.3.3.2.1 requires all chute loading doors shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over twenty residents, staff and visitors on the third floor.<br><br>Findings include:<br><br>Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, the latching mechanism for the laundry chute door on the third floor in the soiled linen room by the elevator failed to work properly which caused the chute door to not self close and latch into the chute's door frame when tested to close multiple times. Based on interview at the time of observation, the Director of Maintenance agreed the aforementioned laundry chute door on the third floor failed to self close and latch into the chute's door frame.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | laundry chute door on the third floor in the soiled utility room has been replaced to latch into the chute's door frame.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- The deficient practice could affect over 20 residents, staff and visitors on the thrid floor.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- An audit has been completed for all laundry chutes in the facility for appropriate self closing latching mechanisms. Maintenance Director/designee will ensure all latching mechanisms are functioning appropriately during pm rounds.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Maintenance Director/designee will assess and conduct any repairs as needed to maintain all latching mechanism work properly.<br><br>5. Date of Compliance.<br>- 5-1-23 | |

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| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Fire Drill Record" with the Executive Director and the Director of Maintenance during record review from 9:45 a.m. to 12:15 p.m. on 04/11/23, documentation of a fire drill conducted on the third shift in the second quarter (April, May, June) 2022 was not available for review. Review of a "Fire Drill Record" for June 2022 at 12:30 was available for review but it did not state what calendar day in June 2022 the fire drill may have been conducted and whether or not the fire drill was conducted at 12:30 a.m. or 12:30 p.m. Based on interview at the time of record review, the Director of Maintenance stated the facility operates three shifts per day, there was staff turnover for the Director of Maintenance | K 0712 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- Unable to correct missed fire drills as drills occured in the past<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- The deficient practice can affect all residents, staff and visitors.<br><br>3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Director will maintain a schedule of fire drills to be conducted monthly for the year | 05/01/2023 |

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| | position last year and the Director of Maintenance agreed documentation of a fire drill conducted on the third shift in the second quarter 2022 was not available for review.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.<br><br>3.1-19(b) | | and ensure all information is completed on the fire drill document.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Maintenance Director will submit monthly fire drill report to the Quality Assurance Committee for review to ensure fire drills are conducted and all documentation is completed.<br><br>5. Date of Compliance.<br>- 5-1-23 | |
| K 0761 SS=F Bldg. 01 | Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this | K 0761 | 1. What corrective actions willbe accomplished for those residents found to have been affected by the deficient practice.<br>- Fire door inspection for all stairwell doors and oxygen storage and transfilling room has been completed.<br><br>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.<br>- The deficient practice could affect all residents, staff and visitors. | 05/01/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155834 | A. BUILDING 01<br>B. WING | 04/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - WILLOW SPRINGS CARE CENTEI | 2002 WEST 86TH STREET<br>INDIANAPOLIS, IN 46260 |

| (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 |
|---|---|---|---|---|
| | Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.<br><br>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include: | | 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>- Maintenance Director will monitor to ensure during inspection and report received therefter lists all fire doors including stairwells and oxygen room are inspected for complaince.<br><br>4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.<br>- Maintenance Director will maintain a log of all fire doors needed for inspection annually and log submitted to the Quality Assurance Committee.<br><br>5. Date of Compliance.<br>- 5-1-23 | |

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| | Based on review of the fire door inspection contractor's "Swing Door Inspection" documentation dated 11/01/22 with the Executive Director and the Director of Maintenance during record review from 9:45 a.m. to 12:15 p.m. on 04/11/23, annual fire door inspection documentation for the facility within the most recent twelve month period did not include all fire door locations in the facility. The 11/01/22 annual fire door inspection documentation did not include stairwell doors on each floor including the basement. The 11/01/22 annual fire door inspection documentation also did not include doors to oxygen storage and transfilling rooms located inside the facility. Based on interview at the time of record review, the Director of Maintenance stated the facility has one oxygen storage and transfilling room located inside the facility on the third floor and agreed the 11/01/22 annual fire door inspection documentation did not include all stairwell doors in the facility. Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 04/11/23, each stairwell door was equipped with a minimum 90-minute fire resistance rating label affixed to the hinge side of the door and each stairwell door self closed and latched into the door frame when tested to close. The facility has one oxygen storage and transfilling room inside the building located on the third floor near the elevator. The corridor door to the oxygen and storage and transfilling room was equipped with a 1-hour fire resistance rating label affixed to the hinge side of the door. The room contained five liquid oxygen containers and eighteen 'E' type oxygen cylinders.<br><br>These findings were reviewed with the Executive Director and the Director of Maintenance during | | | |

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|---|---|---|---|---|
| | the exit conference.<br><br>3.1-19(b) | | | |