STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING -- B. WING	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENT	2905 W SYCAMORE ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/13/22 Facility Number: 000258 Provider Number: 155367 AIM Number: 100289160 At this Emergency Preparedness survey, Brickyard Healthcare-Sycamore Village Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 110 certified beds. At the time of the survey, the census was 97. Quality Review completed on 10/14/22	E 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.¿¿ ¿ The facility respectfully requests a desk review of our responses to this survey.¿	
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 Date: 10/13/22 Facility Number: 000258 Provider Number: 155367 AIM Number: 100289160 At this Life Safety Code survey, Brickyard	K 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.¿¿	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaushik Patel	Executive Director	10/28/2022

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-Sycamore Village Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, battery powered smoke detectors in all resident rooms in the building. The facility has a capacity of 110 and had a census of 97 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached wooden shed used for storage which was not sprinklered. Quality Review completed on 10/14/22		¿ The facility respectfully requests a desk review of our responses to this survey.¿	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall			

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	be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.			

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	18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 exit doors 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 over 20 residents in one exit corridors. Findings include: Based on observation with the Maintenance Director on 10/13/22 at 11:40 a.m., the section 3 short hall exit door was marked as a facility exit, was magnetically locked, and had a posted four-digit code on the access control pad. When the posted code was entered into the keypad the door would not open. Based on interview at the time of observation, the Maintenance Director stated the code to the door was changed and the new code was not posted. The finding was reviewed with the Maintenance Director and the DON during the exit conference.	K 0222	What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Maintenance Director immediately corrected deficient by placing a new four-digit code on the magnetic door pad and ensured that the door is opening. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: This deficient practice could affect over 20 residents in one exit corridor. The Maintenance Director has completed the inspection of ALL EXIT DOORS to ensure each door with magnetic keypad has a working code posted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The task is added to the Building Engines reporting system as a part of Door security check. The maintenance director/designee will	11/04/2022

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	3.1-19(b)		include the door safety check during facility walkthrough. 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/Designee will submit the inspection report at the QAPI meeting.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 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 do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)			

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	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 3 of 9 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/13/22 between 10:30 a.m. and 12:00 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) The door to room 314 which was larger than 50 square feet and contained over 10 boxes of supplies was self-closing but did not automatically latch into the door frame. b) The door to room 316 which was larger than 50 square feet and contained over 10 boxes of supplies was self-closing but did not automatically latch into the door frame. c) The door to the100-hall mechanical room which contain a fuel fired water heater was self-closing but did not automatically latch into the door frame. Based on interview at the time of observation, the Maintenance Director agreed the rooms were hazardous areas and the doors to the rooms did not latch into the frame. This finding was reviewed with the DON and	K 0321	p paraid="829181131" paraeid="{eeac451e-c317-4d33-88e6-4a7b300076d8}{77}" >What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Maintenance Director has completed inspection of the corridor doors to hazardous rooms for self-closing devices. The self-closing latch device was installed to the door to room 314 which was larger than 50 square feet and contained 10 boxes of supplies ol class="NumberListStyle4 SCXW223909254 BCX0" role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-alpha;" The self-closing latch device was installed to the door to room 316 which was larger than 50 square feet and contained over 10 boxes of supplies. The self-closing latch device was	11/04/2022

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	Maintenance Director during the exit conference. 3.1-19(b)		replaced to the door to the 100 Hall mechanical room which contained fuel fired water heather. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The deficient practice has potential to affect 40 residents in the area. The Maintenance director has completed the inspection of all rooms with self-closing devices. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The tasks have been added to the Building Engine reporting system as a part of rounding checks. The maintenance director/designee will observe the proper functioning of the self-closing door latch during the facility walk through. How the corrective actions will be monitored to ensure that the deficient practice will not recur, I.e., what quality assurance program will be in place: Maintenance Director will submit	

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			the inspection report at QAPI meeting.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * 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 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * 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. 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 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment	K 0324	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Maintenace Director has completed the installation of shut of device with an access to turn on and off the cooking equipment located in Activity Room. How other residents having the	11/04/2022

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	is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect 10 residents in the activities room. Findings include: Based on observation with the Maintenance Director on 10/13/22 at 11:14 a.m., there was a cooktop in the activities room that was separated from the corridor, but staff were unable to deactivate the cooktop from power. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop and lock the switch. The Maintenance director stated there is not a shut off switch to the cook top. The finding was reviewed with the Maintenance Director and the DON during the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The deficient practice could have potential to affect 10 residents in the activity room. The shut of device has been installed to provide immediate access for people using the cooking equipment. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director has completed facility wide inspection of all cooking equipment to ensure that there is access to shut on and off. The tasks have been added to the Building Engine reporting system as part of Quarterly Maintenance. How the corrective actions will be monitored to ensure that the deficient practice will not recur, I.e. What quality assurance program will be in place: The maintenance director will submit the report at QAPI meeting.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords			

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	Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 10/13/22 at 11:05 a.m., a toaster and coffee pot (high power draw equipment) were plugged into and supplied power by a power strip at the section 3 nurses station. Based on interview	K 0920	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Maintenance Director unplugged the equipment that was plugged into power strip at the nurse's station. The power strip was removed from the nurse's station. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The deficient practice had potential to affect up to 20 residents. The Maintenance Director has completed facility	11/04/2022

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	at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. The finding was reviewed with the Maintenance Director and the DON during the exit conference. 3.1-19(b)		wide inspection of improper usage of extension / power cords and taken necessary corrective steps. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/Designee will complete staff training on Electrical Safety and appropriate usage of Power Strips. The tasks been added to the Building Engine reporting system as a part of the Quarterly inspection. How the corrective actions will be monitored to ensure that the deficient practice will not recur, I.e. What quality assurance program will be in place: The maintenance director will submit the report at the QAPI meeting.	