STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING -- B. WING	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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: 10/19/23 Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400 At this Emergency Preparedness survey, Brickyard Healthcare - Twelfth Street 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 87 certified beds. At the time of the survey, the census was 62. Quality Review completed on 10/20/23	E 0000	**Brickyard 12th St Care Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/19/23 Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400 At this Life Safety Code survey, Brickyard Healthcare - Twelfth Street Care Center was found	K 0000	**Brickyard 12th St Care Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Rodriguez	Administrator	11/03/2023

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	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. The one-story facility constructed in 1965 and 1966 was determined to be of Type IV (2HH) construction and fully sprinklered. The 1986 one story therapy addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke detectors are provided all resident sleeping rooms. The building is fully protected by a 100-kW diesel powered generator. The facility has a capacity of 87 and had a census of 62 at the time of the survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except an unsprinklered garage and storage shed. Quality Review completed on 10/20/23			
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,			

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	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, record review and interview, the facility failed to maintain 1 of 1 kitchen commercial cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) as required by NFPA 101, Life Safety Code (2012), Section 9.2.3. NFPA 96, Section 10.2.6 states that automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and NFPA 17A(09), Standard for Wet Chemical Extinguishing Systems where applicable. This deficient practice could affect approximately all kitchen staff and 15 residents who use the adjacent dining room. Findings include: Based on record review with the Maintenance Director on 10/19/23 between 09:38 a.m. and 11:38 a.m., The Kitchen Suppression System Inspection dated 09/24/23 stated that "Upon hood system activation electrical did not shut off safecare to correct at future date." The condition was labeled as a deficiency and listed that the automatic	K 0324	**K324E Cooking Facilities (Kitchen Suppression System)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Kitchen Suppression hood system repaired, and no further repairs needed for the shut off of the kitchen suppression system. no ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current kitchen staff & approximately 15 residents who use the adjacent dining room have the potential to be affected by this alleged deficient practice. Audit completed of suppression system	11/20/2023

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	portion of the system did not operate correctly due to the aforementioned issue. Based on interview at the time of record review, the Maintenance Director was unaware of the issue and made a phone call to SafeCare where they had confirmed the deficiency and stated repairs have not been made. An email obtained from SafeCare during the survey listed that scheduled repairs are supposed to happen next week. The deficiency was also noted on inspections dated 03/13/23 and 09/27/22. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		to ensure there were no deficient findings. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director educated on the standard for ventilation control and fire protection of commercial cooking operations. Maintenance Director/Designee will audit System annually by contracted professionals to ensure that suppression system is functioning properly. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/designee will complete audit tool to eliminate the potential for any deficient practices. The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance** **11/20/23**	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the mechanical room and 1 of 1 sprinkler heads in kitchen freezer were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 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: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 20 residents and staff.	K 0353	**K353 Sprinkler System Maintenance and Testing (Corroded Sprinkler heads)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Mechanical Room and Kitchen freezer sprinkler heads cleaned and sprinkler heads in courtyard have been serviced and parts ordered. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential**	11/20/2023

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	Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/19/23 between 11:42 a.m. and 1:16 p.m. the following sprinkler heads were coved in dust or showed signs of loading, a) Two sprinkler heads in the mechanical room, next to the kitchen, were loaded with dust and debris. b) One sprinkler head in the walk-in freezer in the kitchen had a black foreign substance across the bulb and sprinkler head that left the color of the bulb barely visible. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed dirt accumulation and loading. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 7 of 7 sprinkler heads in areas with moisture in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 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: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 40 residents in three		**to be affected by the same deficient practice and what corrective action will be taken?** All current residents and staff have the potential to be affected by this alleged deficient practice. Audit completed of all sprinkler heads to ensure they are free from buildup and dust. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director was educated on sprinkler maintenance and standards. Maintenance Director/Designee will audit sprinkler heads quarterly to ensure they are clean and free of debris or corrosion are fully functional. Audits will include all units. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/designee will complete audit tool to ensure the sprinklers are free from corrosion and debris. The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the	

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	smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/19/23 between 11:42 a.m. and 1:16 p.m. the sprinkler heads in the courtyard near station two hall showed signs of corrosion and greening. Based on interview at the time of observation, the Maintenance Director confirmed that the sprinkler heads showed signs of corrosion. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance 11/20/23**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect approximately 6 residents and staff. Findings include:	K 0511	**K511 -Utilities-Gas and Electric (GFCI)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** GFCI (Ground fault circuit interrupter) in showers one and two were replaced. No ill effect due to alleged deficient practice.	11/20/2023

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	Based on observation with the Maintenance Director on 10/19/23 between 11:42 a.m. and 1:16 p.m., when the GFCI electric receptacles in the shower rooms of Station one and Station two were tested with a GFCI tester. When tested, the GFCI receptacles failed to trip and did not break the electrical circuit. The GFCI tester indicated that both outlets had "open ground". Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned issue and stated he would look into why they weren't operating correctly. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents and staff have the potential to be affected by this alleged deficient practice. Audit completed of all GFCI's in house to ensure that they're all in working condition. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director was educated that all areas in the building that require GFCI's are to be in working condition. Maintenance Director/Designee will audit random GFCI's within the building monthly x 6 months to ensure they're in working condition. Audits will include all units. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/Designee will complete audit tool to ensure that areas of the building that contain GFCI receptacles are functioning properly. The Maintenance	

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			Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance** **11/20/23**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.			

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	(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 12 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/19/23 between 11:42 a.m. and 1:16 p.m., cigarette butts were disposed on the ground in and around the smoking area and along the sidewalk adjacent to the smoking area near the main entrance. Also, outside of the facility near the maintenance shed there were approximately 20 cigarette butts disposed on the ground. Based on interview at the time of observations, the Maintenance Director stated that he frequently cleans the areas, but agreed that there were excessive amounts of improperly discarded cigarette butts. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0741	**K741 (Smoking Regulations)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All cigarette butts located outside around the assigned smoking area near the main entrance, sidewalk and outside near the maintenance shed were disposed of in a noncombustible container. No ill effect noted due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current staff and residents have the potential to be affected by this alleged deficient practice. Audit completed of all above listed areas to ensure that no other cigarette butts were improperly disposed of. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff and all smoking residents were educated on the	11/20/2023

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			facility smoking property and proper disposal of cigarettes. Maintenance Director/Designee will audit 5 exit door areas 5x a week x 6 months to ensure that there are no cigarette butts. Audits will include all units. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/designee will complete audit tool to ensure sidewalk, maintenance shed area and the assigned staff smoking area remain free from cigarette butts. The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance** **11/20/23**	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies,			

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	except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, record review and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/19/23 between 11:42 a.m. and 1:16 p.m., a portable space heater was located in the House Keeping office. Based on record review between 09:38 a.m. and 11:38 a.m., the facility provided a space heater policy that indicated that they were not allowed in the facility in offices or resident areas. Based on interview at the time of the observation and record review, the Maintenance Director confirmed that space heaters were not allowed in the facility and had no maintenance program for them. The Maintenance Director acknowledged that a space heater was in the office. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0781	**K781 Portable Space Heaters (Housekeeping Office Heater)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Space heater immediately removed from the building. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents have the potential to be affected by this alleged deficient practice. Full house audit to ensure there are no space heaters in the building. Weekly audits to occur to ensure there are no space heaters in house. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director and all staff were educated on portable space heater policy. Maintenance	11/20/2023

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			Director/Designee will audit building weekly x 6 months to ensure that the building remains free from space heaters. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/designee will complete audit tool to ensure there are no space heaters in the building at any time. The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance** **11/20/23**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING 01 B. WING	10/19/2023

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	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 flexible cords were not used as a substitute for fixed wiring. 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 approximately 20 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/19/23 between 11:42 a.m. and 1:16 p.m., there was an extension cord in the med room at the station two nurses desk that powered a mini fridge for medications. Based on interview at the time of observation, the Maintenance Director confirmed that the fridge was plugged into an extension cord. The extension cord was removed upon observation.	K 0920	**K920 Electrical Equipment (Power cords/Extension cords)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Extension cord removed from Station 2 med room mini fridge. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All current residents/staff have the potential to be affected by this alleged deficient practice.	11/20/2023

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	The finding was reviewed with the Maintenance Director and the Executive Director during the exit conference. 3.1-19(b)		Audit completed of entire building to ensure that there were no extension cords/power cords being utilized. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff was educated on the prohibition of extension/power cord use in the building. Maintenance Director/Designee will audit office areas 5x a week x 6 months to ensure there are no extension/power cords being utilized. Audits will include all shifts. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Maintenance Director/designee will complete audit tool to ensure that extension/power cords are not being utilized in the med room or throughout the building. The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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