

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155120	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED 11/21/2022
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NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 745 N SWOPE ST GREENFIELD, IN 46140
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 11/21/22</p> <p>Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170</p> <p>At this Emergency Preparedness survey, Brickyard Healthcare - Brandywine Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 128 certified beds. At the time of the survey, the census was 96.</p> <p>Quality Review completed on 11/28/22</p>	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.	
E 0004 SS=C Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
K Lingle	Executive Director	12/11/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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	<p>Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>. Based on record review and interview, the facility failed to review and update the Emergency</p>	E 0004	All occupants have the potential to be affected by the alleged deficient	12/12/2022

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E 0029 SS=C Bldg. --	<p>Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 11/21/22 between 10:15 a.m. and 1:15 p.m., the EEP maintained by the Executive Director and Maintenance Director was updated annually with a date of 7/7/22. However, the EPP from the Nurses Station cover page indicated the most recent review of the EPP from the Nurses Station was 05/14/21, and no date could be found to show the EPP from the Nurse Station was reviewed and updated within the last year. Based on an interview during records review, the Executive Director stated she was unaware that the Nurses Station contained a copy of the EPP.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain</p>		practice. EP binders are currently up to date. Binders will be presented and reviewed in QAPI no less than quarterly in perpetuity for monitoring and observation by the team. Monthly audit of necessary changes by ED or designated representative to be printed and placed in binder.	

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E 0041 SS=F Bldg. --	<p>an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 11/21/22 between 10:15 a.m. and 1:15 p.m., the EEP maintained by the Executive Director and Maintenance Director was updated annually with a date of 7/7/22. However, the EPP from the Nurses Station cover page indicated the most recent review of the EPP from the Nurses Station was 05/14/21, and no date could be found to show the EPP from the Nurse Station was reviewed and updated within the last year. Based on an interview during records review, the Executive Director stated she was unaware that the Nurses Station contained a copy of the EPP. The contact information for facility staff in the Nurse Station EPP was not current.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and</p>	E 0029	All occupants have the potential to be affected by the alleged deficient practice. EP binders are currently up to date. Binders will be presented and reviewed in QAPI no less than quarterly in perpetuity for monitoring and observation by the team. Monthly audit of necessary changes by ED or designated representative to be printed and placed in binder.	12/12/2022

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	<p>standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency</p>			

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

PRINTED: 12/14/2022

FORM APPROVED

OMB NO. 0938-039

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	<p>power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p>			

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	<p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 11/21/22 between 10:15 a.m. and 1:15 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year, 4-hour load test. This was confirmed by the Maintenance Director, who stated he reached out to the contractor who services the generator, and they did not have a record of the test occurring.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p>	E 0041	All occupants have the potential to be affected by the alleged deficient practice. The 4 hour load test has been completed. The task was placed in the Building Engines electronic maintenance system for tracking purposes. The 4 hour load testing will be printed and placed in the life safety manual and be presented to QAPI no less than quarterly.	12/12/2022

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K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 11/21/22</p> <p>Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170</p> <p>At this Life Safety Code survey, Brickyard Healthcare - Brandywine 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.</p> <p>This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas not separated from the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 128 and had a census of 96 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 11/28/22</p>	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.	
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K 0222 SS=E Bldg. 01	<p>NFPA 101 Egress Doors Egress Doors</p> <p>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</p> <p>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 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</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>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</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p>			

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	<p>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</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through the several exits was 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 40, staff and visitors if needing to exit the facility.</p> <p>Findings include:</p>	K 0222	Over 40 staff and residents have the potential to be affected by the alleged defective practice. An audit of egress doors has been completed. Codes are currently posted at each door. No special knowledge is required to exit the building. Inspection of egress doors code postings was placed in the Building Engines electronic maintenance system for tracking purposes. The audit will be printed and placed in the life safety binder and presented to QAPI no less than quarterly for monitoring and	12/12/2022
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K 0321 SS=E Bldg. 01	<p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., the (1) Main Entrance exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code posted at the exit was a series of alternating Blue and Yellow numbers, to exit the facility you had to have special knowledge of which color numbers to use. This practice was repeated at other facility exits such as the (2) Therapy Exit. Additionally, at the (3) Employee Exit and (4) Ambulance Exit the code was not posted.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>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</p>		observation by the team.	

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	<p>REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>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) 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)</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 4 residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., The DCE Office, greater than 50 square feet contained a number of combustible items, such as 9 large cardboard boxes. The corridor door to this office was not provided with a self-closing mechanism. The door did not self-close and latch into the door frame when tested.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p>	K 0321	More than 4 residents, as well as staff and visitors have the potential to be affected by the alleged deficient practice. An audit was completed of corridor doors and latches. A self-closing mechanism has been installed on DCE office door. This task is a daily observation in Building Engines electronic maintenance system for tracking purposes. The audit will be printed and placed in the life safety binder and presented to QAPI no less than quarterly in perpetuity for monitoring and observation by the team.	12/12/2022
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(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
K 0331 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s).</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 75 rooms were provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect over 2 staff.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., approximately a 12'X18" hole was noted in the wall near the compressor in the riser room, which exposed wood studs in the wall.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance</p>	K 0331	Over 2 staff have the potential to be affected by the alleged defective practice. The 12" x 18" hole in the wall has been repaired. Auditing for this deficiency is a daily task in Building Engines electronic maintenance system for tracking purposes. The audit will be printed and placed in the life safety binder and presented to QAPI no less than quarterly in perpetuity for monitoring and observation by the team.	12/12/2022

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K 0341 SS=E Bldg. 01	<p>Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.</p> <p>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 20 residents in one smoke compartment.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., in the</p>	K 0341	More than 20 residents have the potential to be affected by the alleged deficient practice. An audit of all smoke detectors has been completed. Safecare has been scheduled to move the 1 smoke detector located within 3' of an air return. Auditing for this deficiency is in Building Engines electronic maintenance system for tracking purposes. The audit will be printed and placed in the life safety binder and presented to QAPI no less than quarterly in perpetuity for monitoring and observation by the team.	12/20/2022

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K 0351 SS=E Bldg. 01	<p>corridor by Room # 45 there was a smoke detector located within 3 feet of an air return vent where air flow would prevent proper operation of the detector.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 4 of 4 closets and 1 of 8 corridors in accordance with</p>	K 0351	Up to 2 residents could be affected by alleged deficient practice. An audit was conducted to ensure the deficient practice	12/12/2022

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	<p>19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could up to 2 residents.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., the Dietary Storage closet contained boxes which were being stored on shelving within 18 inches of the ceiling and close to the sprinkler heads. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler heads were obstructed and did move some of the items.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system piping was not use to support Non-System Components accordance with NFPA 13, 2010 edition, Section 9.1.1.7 Support of Non-System Components. Sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect 20 residents.</p>		<p>does not exist elsewhere. The top shelf in the Dietary Storage Closet has been removed. Auditing for this deficiency is in Building Engines electronic maintenance system for monthly tracking purposes. The audit will be presented monthly to QAPI no less than quarterly in perpetuity for monitoring and observation by the team.</p>	

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K 0353 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., in the attic near the firewall, a sprinkler pipe had run of HVAC flex pipe laying on top of the sprinkler pipe.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>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.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises.</p>	K 0353	All residents and staff in the facility have the potential to be affected by the deficiency. Sprinkler heads are stored	12/12/2022

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K 0363 SS=E	<p>NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., there was one spare sprinkler cabinet in the riser room that included spare sprinklers; 6 of which were not in their own protected slot. They were stored loose in the cabinet and not secured in holders. Based on interview at the time of the observation, the Maintenance Director agreed the spare sprinkler cabinet had spare sprinklers not in protected slots.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridor - Doors</p>		correctly in the designated cabinet, with the sprinkler wrench. Auditing for this deficiency is in Building Engines electronic maintenance system for monthly tracking purposes. The audit will be presented to QAPI no less than quarterly in perpetuity for monitoring and observation by the team.	

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Bldg. 01	<p>Corridor - Doors</p> <p>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.</p> <p>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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing</p>			

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	<p>devices, etc.</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 4 staff and 4 residents.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., the corridor door to (A) Resident Room 43 failed to close and latch positively into the door frame. Additionally, (B) the corridor door to the Linen Closet near RR #16, equipped with a self-closing mechanism, failed to self-close and latch into the door frame.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 8 residents.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., the following corridor doors had holes which penetrated completely through the door:</p> <p>A) A 1/2 inch hole through the door above the latching hardware in the Medical Room near the</p>	K 0363	4 staff and 4 residents could be affected by alleged deficiency. An audit was completed on all doors in the facility for closing and latching. All doors in the facility are currently closing and latching correctly. Auditing for this deficiency is in Building Engines electronic maintenance system for daily tracking purposes. The audit will be presented no less than quarterly in perpetuity for monitoring and observation by the team.	12/12/2022

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K 0511 SS=E Bldg. 01	<p>cafeteria.</p> <p>B) The ACU Unit Shower door was disintegrated down the side leaving a 1-inch gap when completely closed and would not resist the passage of smoke.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>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 3 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. 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(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles</p>	K 0511	Up to 6 residents and staff could be affected by alleged deficiency. GFCIs have been installed in all cited locations. An audit was completed to ensure that all circuits are protected. A monthly audit is in Building Engines to ensure continued compliance. The audit will be presented to QAPI no less than quarterly in perpetuity for monitoring and observation by the team.	12/12/2022

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	<p>installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.</p> <p>(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors</p> <p>Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable.</p> <p>Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection.</p> <p>(5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink.</p> <p>Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection.</p> <p>Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required.</p> <p>(6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand</p>			

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K 0712 SS=F Bldg. 01	<p>tools.</p> <p>NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 6 residents and staff.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., the following locations were not equipped with GFCI outlets or a GFCI Circuit:</p> <p>A) In the Laundry Area, two outlets behind the commercial washers were not protected.</p> <p>B) The free-standing Ice machine, with it's own water supply in the Clean Utility area was not connected to a GFCI protected outlet or circuit. Additionally, the GFCI outlet not in use in the aforementioned room did not trip when tested.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Drills Fire Drills 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.</p>			

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NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 745 N SWOPE ST GREENFIELD, IN 46140
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	<p>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.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 11/21/22 between 10:15 a.m. and 1:15 p.m., the following shifts were missing documentation of a completed fire drill:</p> <p>a) A second shift fire drill in the second quarter of 2022.</p> <p>b) A first shift fire drill in the third quarter of 2022.</p> <p>Based on interview at the time of record review, the Maintenance Director stated he was unsure if the aforementioned drills were conducted.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0712	This alleged deficiency could affect all residents and staff. Fire drills will be conducted once per shift per quarter and be co-signed by the ED or DNS for verification that all fields are properly filled out upon completion. A reminder for monthly fire drills has been added to Building Engines electronic maintenance system for monthly tracking purposes. The completed fire drills will be brought to QAPI no less than quarterly for monitoring purposes in perpetuity.	12/12/2022

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K 0741 SS=E Bldg. 01	<p>NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(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.</p> <p>(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.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(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.</p> <p>18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect 5 staff around the side exit.</p> <p>Findings include: Based on observations and interview during a</p>	K 0741	This deficient practice could affect 5 staff around the side exit. Smoking Policy reviewed and updated as needed. Staff in-serviced on smoking policy. Policy reviewed no less than quarterly in QAPI.	12/12/2022

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K 0918 SS=F Bldg. 01	<p>tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., smoking on property was evident as a CNA was observed smoking immediately outside the exit near resident room 66. Based on records review the smoking policy provided stated smoking is not allowed on the facility's property.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder</p>			

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	<p>circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.</p> <p>Findings include:</p> <p>Based on records review and interview with the Maintenance Director on 11/21/22 between 10:15 a.m. and 1:15 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three- year, 4 hour load test. This was confirmed by the Maintenance Director, who stated he reached out to the contractor who</p>	K 0918	All occupants of facility have the potential to be affected by alleged deficient practice. 4 hour load test was completed. This audit is in Building Engines electronic maintenance system for monthly tracking purposes. This audit will be brought to QAPI no less than quarterly monitoring purposes in perpetuity.	12/12/2022

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K 0920 SS=E Bldg. 01	<p>services the generator, and they did not have a record of the test occurring.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p> <p>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) assemblies 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</p>	K 0920	This deficient practice affected 2	12/12/2022

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	<p>failed to ensure 1 of 1 resident room did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 resident.</p> <p>Findings include:</p> <p>Based on observations and interview during a tour of the facility with the Maintenance Director on 11/21/22 between 1:15 p.m. and 3:45 p.m., room 54 contained a multi-plug adaptor powering a TV, clock and other electronics. Based on interview at the time of observation, the Maintenance Director agreed a mulita-plug adaptor was in use in room 54.</p> <p>This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present.</p> <p>3.1-19(b)</p>		<p>residents. An audit was completed of all resident rooms. At this time, all rooms are in compliance. This audit is in Building Engines electronic maintenance system for monthly monitoring. Audit to be presented to QAPI no less than quarterly. Staff in-serviced as to the importance of reporting violations.</p>	