STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155120	A. BUILDING -- B. WING	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 11/21/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/06/23 Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170 At this PSR Emergency Preparedness survey, Brickyard Health Care - Brandywine was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 128 certified beds. At the time of this PSR survey, the census was 96. Quality Review completed on 01/10/23	E 0000	Preparation, submission, and implementation of this plan of corrections does not constitute an admission or agreement with the facts and conclusions set forth on the survey reports. Our plan of correction was prepared and executed as 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. This is the facility Directed Plan of Correction.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/21/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/06/23 Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170	K 0000	Preparation, submission, and implementation of this plan of corrections does not constitute an admission or agreement with the facts and conclusions set forth on the survey reports. Our plan of correction was prepared and executed as means to continuously improve the quality of care and comply with all applicable federal and state	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keary Dye	Transitional ED	01/23/2023

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

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	At this PSR Life Safety Code survey, Brickyard Health Care - Brandywine 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 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 PSR survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/10/23		requirements. The facility respectfully requests a desk review of our responses to this survey. This is the facility Directed Plan of Correction.	
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 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. Findings include: Based on observations and interview during a tour of the facility with the Interim Executive Director on 01/06/23 between 2:50 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, which was now described in an attached sign above the code pad. However, the yellow numbers (which are the operative numbers to exit the facility) are light in color and not easily legible and could be a challenge to someone needing to	K 0222	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? New signs were posted. The sign numbers are black in color and are easily readable. It requires no special knowledge. · How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents have the potential for being affected. · What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not re-occur? The maintenance department will be in-serviced on posting an easy legible code without any special instructions. Audits will be completed on all exit access doors weekly x 1 month. Then every two weeks for x 1 month. Then 1 time each month for 4 months.	01/12/2023

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	exit the facility. This practice was repeated at other facility exits such as the (2) Therapy Exit. Additionally, at the (3) Employee Exit. This finding was acknowledged by the Interim Executive Director at the time of observation and again at the exit conference with the Interim Executive Director and her son present. This deficiency was cited on 11/21/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		The audits will conducted by the Maintenance Director or designee. The Executive Director will monitor for compliance. · How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place? Results of these audits will be brought to QAPI monthly and reviewed x 6 months to identify any concerns and to make any recommendations. If any concerns are identified, they will continue audits based on QAPI. They will continue audits based on QAPI recommendations.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 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. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible			

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	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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 8 residents. Findings include: Based on observations and interview during a tour of the facility with the Interim Executive Director on 01/06/23 between 2:50 p.m. and 3:45 p.m., 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. This finding was acknowledged by the Interim Executive Director at the time of observation and again at the exit conference with the Interim	K 0363	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A new door was installed on January 12, 2023. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? There are 8 residents that have the potential for being affected. What means will be put into place	01/12/2023

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	Executive Director and her son present. This deficiency was cited on 11/21/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		and what systemic changes will be made to ensure the deficient practice does not re-occur? The Maintenance Department will be in-serviced on doors protecting corridor opening must resist the passage of smoke. Audits will be completed on corridor doors .Audits will be completed weekly x 1 month than bi-weekly x 1 month than x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality program will be put into place. Results of the audits will be brought to QAPI monthly and reviewed x 6 months to identify any concerns and to make any recommendations. If any concerns are identified, they will continue audits based on the QAPI. If none noted, they will complete audits as needed.	