STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155834	A. BUILDING -- B. WING	07/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/16/24 Facility Number: 013738 Provider Number: 155834 AIM Number: 100272170 At this Emergency Preparedness survey, Brickyard Healthcare - Willow Springs Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 134 certified beds. At the time of the survey, the census was 54. Quality Review completed on 07/22/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/16/24 Facility Number: 013738 Provider Number: 155834 AIM Number: 100272170 At this Life Safety Code survey, Brickyard	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sonia Patel	Executive Director	08/02/2024

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

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	Healthcare - Willow Springs Care Center was found not compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three-story facility with a basement was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 134 and had a census of 54 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/22/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 5 exit discharges for the first floor were continuously maintained free of obstruction to full use in case of emergency. This	K 0211	Preparation or excecution of the Plan of Correction does not constitute admission or agreement or conclusion set forth on the	08/05/2024

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	deficient practice could affect 10 residents, staff and visitors if needing to exit the facility from the Therapy Room on the first floor. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, the exit door to the outdoor courtyard from the Therapy Room on the first floor was marked as a facility exit with an exit sign. The hard surface path of egress to the public way in the courtyard outside the Therapy Room leads to a courtyard gate. Two portable cooking grills were stored on the hard surface path of egress to the public way in the courtyard near the gate and would have to be moved in order to utilize the path of egress to the courtyard gate. Based on interview at the time of the observations, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center agreed the storage of the cooking grills in the path of egress in the courtyard did not ensure the Therapy Room exit discharge was continuously maintained free of obstruction to full use in case of emergency. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)		statement of deficiencies. The Plan of Correction is prepared and excecuted solely because it is required by the position of Federal and State law. The Plan of Correction is submitted to respond to allegations of non compliance cited. Please accept this Plan of Correction as the provider's credible allegation of compliance. The provider respectfully requests desk review and paper compliance to be considered in establishing that the provider is in compliance. 1. The two portable cooking grills stored on the hard surface path of egress to the public way in the courtyard has been moved to a different location. 2. This deficient practice could affect 10 residents. All egress areas have been check to ensure all areas are clear. 3. Maintenance have been educated on having egress areas clear at all times. 4. Maintenance Director/designee will monitor daily during rounds to ensure that all egress areas are clear of any blockage in the pathway. 5. Date of compliance: 8-5-24	
K 0222 SS=E	NFPA 101 Egress Doors			

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Bldg. 01	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 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			

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	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. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 14 exits and 1 of 1 courtyard exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the Therapy Room on the first floor. Findings include:	K 0222	1. Code has been posted to the egress through the courtyard. 2. This deficient practice could affect over 10 residents, staff and visitors. 3. A 15 second egress maglock has been installed on the Therapy door to the courtyard and a code has been posted for access from the patio gate. An audit of all doors with keypads have been completed to ensure codes are posted. 4. Maintenace Director/designee	08/05/2024

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	Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, the exit door to the courtyard from the Therapy Room on the first floor was marked as a facility exit with an exit sign. The exit door could only be opened by employees by using a swipe card at the exit door to release the magnetic locking device on the door. In addition, the courtyard for the Therapy Room exit discharge had one locked gate in the path of egress to the public way. The door was locked with a keypad which could be unlocked by entering a code at the keypad but the code to release the gate to open was not posted at the gate. Based on interview at the time of the observations, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center stated the facility does not have a dedicated wing or area for residents which require specialized security measures and agreed the Therapy Room exit door required an employee swipe card to release the door to open and the code to release the locked courtyard gate to open was not posted at the courtyard gate. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)		will monitor daily during rounds to ensure code is posted and report any descrepancies. 5. Compliance date:	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection			

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	requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors installed in all resident sleeping rooms was complete. NFPA 101 in Section 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Detectors: Change batteries in battery-operated smoke detectors" documentation dated 07/05/23 with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center, resident sleeping room smoke detector cleaning documentation for the most recent twelve month period was not available for review. Review of "Resident Room Monthly Smoke Detector Battery Test" documentation for the most recent twelve month period indicated resident sleeping room smoke detectors are tested	K 0300	1. The old smoke detector was changed out to match all other i9050 smoke detectors. 2. This deficient practice could affect all residents, staff and visitors. 3. Smoke detectors have been placed on a preventative maintenance schedule for compliance. An audit of all smoke detectors have been completed. 4. Maintenance Director/dsignee will follow scheduled maintenance for all smoke detectors. 5. Date of Compliance: 8-5-24	08/05/2024

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	on a monthly basis but battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Assistant stated resident sleeping room smoke detectors are cleaned each time they are tested but agreed battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review. Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, all resident sleeping room smoke detectors are battery operated. Manufacturer's documentation affixed to the Kidde Model i9050 smoke detector installed on the wall in resident sleeping Room A307 stated "clean the detector annually". In addition, Manufacturer's documentation affixed to the First Alert Model SA 710 smoke detector installed on the wall in resident sleeping Room A326 stated "clean the detector monthly". These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)			
K 0324 SS=D 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			

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	appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect over three kitchen staff and visitors. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35	K 0324	1. Drip Tray has been installed in the kitchen range hood system. 2. This deficient practice could affect over 3 kitchen staff and visitors. 3. Monitoring of the kitchen rangehood system with drips tray in place have been placed on the routine maintenance schedule. 4. Maintenance Director/designee will monitor during rounds to ensure all drip trays are in place. 5. Compliance Date: 8-5-24	08/05/2024

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	p.m. on 07/16/24, one of two designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. The two designated locations for a grease container each had a one inch in diameter hole in the drip tray beneath the system filters and had an affixed bracket for holding a container, but no container was present for one of the designated locations. Based on interview at the time of the observations, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center agreed of the two designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	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.			

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	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) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 linen closets on the second floor in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the second floor linen closet by Room A234. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, one of one ceiling mounted sprinkler locations in the linen closet on the second floor by Room A234 had a missing escutcheon. Based on interview at the time of the observations, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center agreed the aforementioned sprinkler location was missing its escutcheon. These findings were reviewed with the Executive Director, the Maintenance Assistant and the	K 0351	1. The escutcheon has been installed in the linen closet on the second floor. 2. The deficient practice could affect 10 residents, staff and visitors in the vicinity. 3. An audit has been completed for the entire facility to ensure all fire sprinklers have an escutcheon. 4. Maintenance Director/designee will maintain scheduled services and documentation to ensure devices are in compliance as needed. 5. Compliance Date: 8-5-24	08/05/2024

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	visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)			
K 0353 SS=E 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 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 4 ceiling smoke barriers. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 5 residents,	K 0353	1. The suspended ceiling tile above the washing machine in the basement laundry room has been put in place. 2. This deficient practice could affect over 5 residents, staff and visitors in the vicinity. 3. Maintenance Director/designee have completed facility assessment to ensure there are no missing or open ceiling areas.	08/05/2024

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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
	staff and visitors in the vicinity of the basement Laundry room. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, one of the suspended ceiling tiles above the washing machines in the basement Laundry room was not in place which did not maintain the ceiling construction in the room. Based on interview at the time of the observations, the Maintenance Assistant agreed the missing ceiling tile did not maintain the ceiling construction in the basement Laundry room. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)		All corrections have been completed 4. Maintenance Director/designee will monitor during daily rounds to ensure that there is no discrepancies of missing tiles or open ceiling areas. 5. Complinace date: 8-5-24	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door	K 0761	1. All Fire door inspections have been completed. 2. This deficient practice could affect over 10 residents, staff and visitors. 3. Maintenance Director/designee will monitor all timely services and review for appropriate completion of services.	08/05/2024

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	155834	A. BUILDING 01 B. WING	07/16/2024

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	assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label.		4. Director of Maintenance/designee will maintain scheduled services and documentation as needed. 5. Compliance date: 8-5-24	

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	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 10 residents, staff and visitors in the basement. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Doors: Inspection-Latch and Gap" documentation dated 10/26/23 and 04/26/24 with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center, annual fire door inspections for the facility did not include stairwell doors in the basement. Based on interview at the time of the review, the Maintenance Assistant stated he was not certain annual fire door inspection documentation included basement stairwell doors and agreed documentation of annual inspection and testing for basement stairwell doors within the most recent twelve month period was not available for review. Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, the basement stairwell door at the north end of the facility and the basement stairwell door at the south end of the facility were each equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. The Executive Director and the visiting Administrator for Brickyard Healthcare-Brookview Care Center provided			

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	"NFPA 80 Fire Door Assembly Inspection" documentation from a fire door inspection contractor dated 07/11/24 during the exit conference which did not include basement stairwell doors. 3.1-19(b)			
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was	K 0914	1. All resident room receptacle testing has been completed. 2. This deficient practice could	08/05/2024

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	available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect over 60 residents, staff and visitors. Findings include: Based on review of "Receptacle Testing" documentation dated 02/22/24 with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center, electrical receptacle inspection and testing documentation for the second and third floor resident sleeping rooms within the most recent twelve month period was not available for review. The 02/22/24 testing documentation was for resident sleeping rooms		affect over 60 residents, staff and visitors. 3. The receptacle testing has been scheduled to be done annually in the Maintenance portal to remind the Maintenance Diretor/designee for completion. 4. Maintenance Director/designee will ensure timely completion of the task to stay in complaince. 5. Compliance date: 8-5-24	

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	on the first floor only. Based on interview at the time of record review, the Executive Director and the Maintenance Assistant stated the facility was in the process of inspecting and testing all resident sleeping room electrical receptacles in the facility but agreed electrical receptacle inspection and testing documentation for second and third floor resident sleeping rooms within the most recent twelve month period was not available for review. Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, resident sleeping rooms on the second and third floors had a mix of hospital-grade and non-hospital-grade receptacles installed in the rooms. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	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.			

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	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 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)			
	Based on observation and interview, the facility failed to ensure overcurrent protective devices in Emergency Power Supply Systems (EPSS) circuits were accessible only to authorized persons. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 6.5.4 states overcurrent devices in EPSS circuits shall be accessible to authorized persons only. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center	K 0918	1. The emergency transfer switches located outside the facility have been secured with a lock and accessible only to authorized persons. 2. This deficient practice could affect all residents, staff and visitors. 3. Maintenance Director/designee will ensure during daily rounds that transfer switches are secured and locked. 4. Maintenance Director/designee	08/05/2024

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	during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, two of two emergency generator transfer switches located outside the facility on the north side of the building were each in an unlocked detached weatherproof storage cabinet. Based on interview at the time of the observations, the Maintenance Assistant agreed the emergency generator transfer switches were each in an unlocked detached weatherproof storage cabinet outside the facility. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)		will monitor daily for compliance. 5. Compliance date: 8-5-24	
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 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			

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	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 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Beauty Salon by Room A227 on the second floor. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, a fan was plugged into an extension cord placed on the floor in the Beauty Salon by Room A227 on the second floor. Based on interview at the time of the observations, the Maintenance Assistant agreed an extension cord was being used as a substitute for fixed wiring at the aforementioned location. These findings were reviewed with the Executive	K 0920	1. Extension cord located in the beauty shop has been removed. 2. This deficient practice could affect over 10 residents, staff and visitors. 3. Maintenance Director/designee completed and audit of the entire facility to ensure there are no extension cords in use. 4. Maintence Director/designee will monitor daily during rounds for any extension cords in use and remove if identified. 5. Compliance Date: 8-5-24	08/05/2024

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	Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."			

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	Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure 2 of 21 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 indoor oxygen storage areas. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near the elevator on the third floor. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, two of twenty-one 'E' type oxygen cylinders stored in the oxygen storage and transfilling room on the third floor by the elevator were not stored in a rack, chained or otherwise secured from falling in a proper cylinder	K 0923	1. All oxygen cylinders have been secured in the oxygne storage room and empty and full cylinders were sorted to their designated empty and full signs and nursing staff trained to do such. 2. This deficient practice could affect over 10 residents, staff and visitors. 3. Maintenance Director/designee has installed additional wall mounts to ensure no oxygen cylinders are stored directly on the grounds and full and empty Oxygen tanks and cylinders are seperated. 4. Maintenance Director/designee will monitor during rounds to ensure all oxygens tanks/cylinders are secured and seperated. 5. Compliance Date: 8-5-24	08/05/2024

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	stand or cart. A total of five liquid oxygen containers and twenty-one 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center agreed two of the twenty-one oxygen cylinders in the oxygen storage and transfilling room on the third floor were not properly chained, stored, secured or supported in a proper cylinder stand or cart. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 21 of 21 oxygen cylinders were segregated from full and empty cylinders and were marked to avoid confusion. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.6.5.2 states if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room near the elevator on the third floor. Findings include: Based on observations with the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center			

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	during a tour of the facility from 1:15 p.m. to 3:35 p.m. on 07/16/24, a total of twenty-one oxygen cylinders and five liquid oxygen containers were stored in the oxygen storage and transfilling room on the third floor by the elevator. Two of five oxygen cylinders were stored next to one another in the room. Pressure gauges attached to the five cylinders indicated two of the five cylinders were empty and the remaining three of the five cylinders were not empty. No provisions to mark or separate full and empty cylinders in the room was noted. Based on interview at the time of the observations, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center agreed the third floor oxygen storage room contained oxygen cylinders that were not marked or separated as full and empty cylinders. These findings were reviewed with the Executive Director, the Maintenance Assistant and the visiting Administrator for Brickyard Healthcare-Brookview Care Center during the exit conference. 3.1-19(b)			