STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING -- B. WING	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - RICHMOND CARE CENTER	1042 OAK DR RICHMOND, IN 47374

(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: 09/30/24 Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Emergency Preparedness survey, Brickyard Healthcare - Richmond 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 122 certified beds. At the time of the survey, the census was 67. Quality Review completed on 10/02/24	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: 09/30/24 Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Life Safety Code survey, Brickyard	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marshall Bowman	Executive Director	10/16/2024

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 - Richmond Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 67 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which were not sprinkled. Quality Review completed on 10/02/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 8 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 12 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance	K 0211	K211 1 The wheelchair was immediately removed 2 All residents in the area have potential to be affected by this deficient practice and the wheelchair was removed. 3 A task was placed in TELS to check for any obstructions to corridor doors and exits which recurs weekly and is ongoing. 4 Maintenance will report to	10/16/2024

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	Supervisor (MS) and Regional Representative on 09/30/24 between 12:40 p.m. and 2:45 p.m., the facility exit door, marked a facility exit, nearest Resident Room #52 was obstructed with a wheelchair positioned in front of the door. The MS stated that this is an ongoing battle with the resident who insists on parking his wheelchair in that location. This finding was acknowledged by the Maintenance Supervisor and Regional Representative at the time of discovery and again at the exit conference with the Maintenance Supervisor, Regional Representative and Executive Director all present. 3.1-19(b)		QAPI no less than quarterly in perpetuity on life safety items to ensure ongoing compliance. 5 Date:__10/16/24_____	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design	K 0324	K324 1 All kitchen cooking equipment under the ANSUL hood was marked at the floor where the wheels are designed to be. 2 All residents in the area adjacent to the kitchen have potential to be affected by the alleged deficient practice. All kitchen cooking equipment under the ANSUL hood was marked at the floor where the wheels are designed to be. 3 A task was placed in TELS to check location of cooking equipment “return plan” marking on the floor around the wheels is in place. 4 Maintenance will report to	10/16/2024

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	location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 5 staff, and no residents. The findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) and Regional Representative on 09/30/24 between 12:40 p.m. and 2:45 p.m., the 4 burner gas range which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the MS, the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was acknowledged by the Maintenance Supervisor and Regional Representative at the time of discovery and again at the exit conference with the Maintenance Supervisor, Regional Representative and Executive Director all present. 3.1-19(b)		QAPI no less than quarterly in perpetuity on life safety items to ensure ongoing compliance. 5 Date:___10/16/24_____	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility	K 0351	K351	10/16/2024

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	did not provide accessible access to the fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) and Regional Representative on 09/30/24 between 12:40 p.m. and 2:45 p.m., the FDC and Post Indicator Valve (PIV) was located in the yard near the end of a parking lot and was obstructed, blocked and not visible due to cars which were parked directly in front of the FDC and PIV. The area was posted "No Parking / You will be Towed" and had faded lines painted on the blacktop. Based on interview, the lot was described as a staff parking lot and the MS stated the towing threat may need to be enforced. This finding was acknowledged by the Maintenance Supervisor and Regional Representative at the time of discovery and again		1 Vehicles were removed from in front of the FDC and post indicator, area was painted to indicate the area is not to be parked in, and a cone was placed in the area to ensure no vehicles were placed there. 2 All residents have potential to be affected by this deficient practice. Vehicles were removed from in front of the FDC and post indicator, area was painted to indicate the area is not to be parked in, and a cone was placed in the area to ensure no vehicles were placed there. 3 A task was placed in TELS to check the FDC and PIV area is unobstructed. 4 Maintenance will report to QAPI no less than quarterly in perpetuity on life safety items to ensure ongoing compliance. 5 Date:____10/16/24_____	

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	at the exit conference with the Maintenance Supervisor, Regional Representative and Executive Director all present. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 5 of over 40 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 8 staff and 4 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Regional Representative on 09/30/24 between 12:40 p.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Resident Room #5, when in the open position, the door drags significantly on the floor and requires much effort to begin to close. b) The Soiled Utility room door on the TCU hall, equipped with a self-closing device, would self-close, but failed to latch. c) Resident Room # 13 failed to latch. d) The corridor door into the laundry area nearest to the dryers, equipped with a self-closing device failed to self-close and latch. e) Resident Room # 18 had a bed positioned that obstructed the door and would not allow the corridor door to close. This condition was corrected during the survey, but conversation suggested that this has been an issue before at this location.	K 0363	K363 1 The doors were repaired to properly close and latch for the resident room #5, #13, #18, and to self-close and latch for the TCU soiled utility door and the corridor door into the laundry area. 2 All residents in the adjacent areas have potential to be affected by this allegedly deficient practice. The doors were repaired to properly close and latch for the resident room #5, #13, #18, and to self-close and latch for the TCU soiled utility door and the corridor door into the laundry area. 3 All doors were checked in the facility to ensure no other of the same alleged deficiency existed, and a task was added to TELS to check all doors monthly for proper closing, latching, and self closing where applicable. 4 Maintenance will report to QAPI no less than quarterly in perpetuity on life safety items to ensure ongoing compliance. 5 Date:__10/16/24_____	10/16/2024

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	This finding was acknowledged by the Maintenance Supervisor and Regional Representative at the time of discovery and again at the exit conference with the Maintenance Supervisor, Regional Representative and Executive Director all present. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) and Regional Representative on 09/30/24 between 12:40 p.m. and 2:45 p.m., in the TCU Nurses Office a power strip was being used to power a microwave oven (high power draw equipment). This finding was acknowledged by the Maintenance Supervisor and Regional Representative at the time of discovery and again at the exit conference with the Maintenance Supervisor, Regional Representative and Executive Director all present. 3.1-19(b)	K 0920	K920 1 The power strip in the TCU nurses office power strip to the microwave oven was removed and the microwave was plugged into the wall directly. 2 All residents in the area adjacent to the TCU nurses office have potential to be affected by the alleged deficient practice. The power strip in the TCU nurses office power strip to the microwave oven was removed and the microwave was plugged into the wall directly. 3 All areas were checked for improper use of power strips and PCREE throughout the facility. An inspection was added to TELS to check for proper use of power strips and PCREE throughout the facility. 4 Maintenance will report to QAPI no less than quarterly in perpetuity on life safety items to ensure ongoing compliance. 5	10/16/2024

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