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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING -- B. WING	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE – PORTAGE CARE CENTER	3175 LANCER ST PORTAGE, IN 46368

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/02/22 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 At this Emergency Preparedness survey, Brickyard Healthcare - Portage 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 186 certified beds. At the time of the survey, the census was 112. Quality Review completed on 08/03/22	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: 08/02/22 Facility Number: 000098 Provider Number: 155187 AIM Number: 100290980 At this Life Safety Code survey, Brickyard	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 - Portage Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a), Life Safety from Fire, the 2012 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. The original building was built in approximately 1978 and the addition, which consisted of 300 Hall, was built in approximately 2005. The entire building 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, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility is fully protected by a 350 kW diesel emergency generator. The facility has a capacity of 186 dually certified for Medicare and Medicaid, and had a census of 112 at the time of this survey. Quality Review completed on 08/03/22			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to properly install exit signage at 1 of over	K 0293	Facility Requests Paper Compliance/Desk review	08/26/2022

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	15 areas of exit discharge or sets of smoke barrier doors in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 08/02/22 between 1:25 p.m. and 2:35 p.m. during a tour of the facility with the Maintenance Director, Maintenance Supervisor, and Executive Director, there was an illuminated EXIT sign on a bulkhead in C Wing leading away from the skilled dining area with both directional arrows uncovered. The arrows being uncovered made the EXIT sign confusing because they did not lead to an exit in either direction. Based on interview at the time of observation, the Maintenance Director agreed the directional arrows of the EXIT sign should not be visible and would have them covered. This finding was reviewed with the Executive Director at the tine of exit.		k**-293** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Exit signs will be altered so that it will not inaccurate direction to facility EXIT doors. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside in the facility have a potential to be affected by this deficient practice. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Maintenance Director or designee will do a facility wide audit to ensure that exit signs are complying with life safety regulations. The EXIT signs that do not meet regulatory standards will be immediately changed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will audit facility exit signs to ensure compliance and any new	

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			EXIT signs that are purchased will meet regulatory standards. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
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 1 of 1 ceiling construction. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 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 at least 15 residents staff in the Memory Care wing.	K 0353	Facility Requests Paper Compliance/Desk Review k**-353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The missing ceiling tile will be installed.	08/23/2022

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	Findings include: Based on observation with the Maintenance Director, Maintenance Supervisor and Executive Director on 08/02/22 at 2:00 p.m., a lay in ceiling tile was missing in the nurse station of the Memory Care wing. This condition could delay the activation of the sprinklers installed in ceilings. Based on interview at the time of observation, the Maintenance Director agreed there was a missing ceiling tile and would have it replaced. This finding was reviewed with the Executive Director at the time of exit. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside in the facility have a potential to be affected by this deficient practice. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Maintenance Director or designee will do a facility wide audit to ensure that facility ceiling tiles are compliant with life safety regulations. The ceiling tiles that do not meet regulatory standards will be immediately changed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will audit facility ceiling three times a week x 1 months and two x week thereafter to ensure that ceiling tiles are in place. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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K 0712 SS=F Bldg. 01	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. 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. 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to ensure 2 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff, and visitors in the facility. Findings include: Based on record review of the documentation entitled "Report of Monthly Fire Drill" with the Maintenance Director on 08/02/22 from 11:05 a.m. to 1:25 p.m., the documentation for the following fire drills failed to include the verification of transmission of the fire alarm signal to the monitoring station: a) 09/29/21 at 11:00 p.m. b) 11/30/21 at 8:30 p.m. Based on interview at the time of record review, the Maintenance Director confirmed that the aforementioned fire drills did not document the	K 0712	Facility Requests Paper Compliance/ Desk Review k**-712** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance department was educated to verify the transition of a fire alarm signal to the monitoring station after a midnight silent fire drill. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside in the facility have a potential to be affected by this deficient practice. **What measure will be put into**	08/23/2022

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	verification of transmission of the fire alarm signal to the monitoring station. This finding was reviewed with the Executive Director at the time of exit.		**place or what systemic changes will be made to ensure that the deficient practices does not recur:** Maintenance Director or designee will sound the alarm within 24 hours after a silent alarm drill to verify the signal had transmitted successfully. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will audit facility monthly x 3 months, then two times per month thereafter to ensure that fire drills include the verification of transmission of the fire alarm signal to the monitoring station for fire drills conducted between 6 AM and 9 PM. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
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			

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	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 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)			
	1. Based on record review and interview, the facility failed to document emergency generator monthly load testing for 4 months of the most recent 12-month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the	K 0918	Facility Requests paper Compliance/ Desk Review k**-918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/23/2022

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	following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Monthly Generator Log" documentation for the most recent twelve-month period with the Maintenance Director during record review from 11:05 a.m. to 1:25 p.m. on 08/02/22, monthly load testing documentation for the facility's diesel fired emergency generator for the months of October, November 2021 and February, March 2022 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed monthly load testing documentation for the aforementioned months was not available for review. 2. Based on record review, observation and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA		**practice?** The facility contacted an outside organization to conduct the monthly 4 hour generator load test. The outside company will provide readings to facility management scheduled 08-19-2022. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside in the facility have a potential to be affected by this deficient practice. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Maintenance will utilize outside contractor to do the monthly 4-hour load test and provide facility with proper documentation with to comply with life safety regulations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Administrator/Maintenance Director/designee will audit one time a month x 6 months to ensure that monthly generator load tests are conducted. Any negative trends will be reviewed in Monthly QAPI program. Any concerns will be monitored	

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	99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.2 states for a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 11:05 a.m. to 1:25 p.m. on 08/02/22, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel powered emergency generator for the facility was not available for review. Based on interview at the time of record review, the Maintenance Director stated supplemental load testing for four hours within the most recent three-year period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:25 p.m. to 2:35 p.m. on 08/02/22, the facility has one diesel emergency generator located outside the building.		through the QAPI process for a minimum of six months and until 95% compliance is achieved.	

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	These findings were reviewed with the Executive Director at the time of exit. 3.1-19(b)			
K 0920 SS=D 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 cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. 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	K 0920	**Facility Requests Paper Compliance/ Desk review** **K-920** **What corrective action(s) will be accomplished for those**	08/23/2022

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	cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff only in the kitchen. Findings include: Based on observation with the Maintenance Director and Executive Director on 08/02/22 during a tour of the facility from 1:25 p.m. to 2:35 p.m., an extention cord was powering a small fan and a bluetooth speaker in the dish area of the kitchen. Based on interview at the time of observation, the Executive Director confirmed that an extension cord was being used as a substitute for fixed wiring in the dish area of the kitchen. This finding was reviewed with the Executive Director at the time of exit. 3.1-19(b)		**residents found to have been affected by the deficient practice?** The extension cord was removed on 8/2/2022. Dietary department has been educated on extension cord policy. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside in the facility can be affected by this deficient practice. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Maintenance director/ designee will audit areas in the facility to remove any unapproved extension cord. Dietary was educated on extension cords in the facility. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Maintenance Director/ designee, will audit random facility areas 3 times a week x 2 months then, 2 times a week for 2 months then 2 times monthly for the duration of 6 months Any negative trends will be reviewed in the monthly QAPI	

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			program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	
K 0923 SS=B 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."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 01 B. WING	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE – PORTAGE CARE CENTER	3175 LANCER ST PORTAGE, IN 46368

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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) Based on observation and interview, the facility failed to ensure 2 of 4 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 15 residents and staff in one smoke compartment. Findings include: Based on observations during a tour of the facility from 1:25 p.m. to 2:35 p.m. with the Maintenance Director, Maintenance Supervisor and Executive Director on 08/02/22, an 'E' type oxygen cylinder was standing upright on the floor in the B Wing nurse's station and was not supported in a cylinder cart or stand. Additionally, an 'E' type cylinder was standing upright in the floor of the B Wing oxygen storage/trans-filling room and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the	K 0923	**Facility Requests Paper Compliance/ Desk Review** **K-923** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The one loose oxygen cylinder was immediate stored in the oxygen closet in the appropriated rack. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside in the facility have the potential to be affected by this deficient practice. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Maintenance director/ designee	08/23/2022

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	time of observation, the Maintenance Director agreed the two 'E' type oxygen cylinders in the aforementioned locations were not properly chained or supported in a proper cylinder stand or cart. The two 'E' type oxygen cylinders were placed in a cylinder cart located in the B Wing oxygen storage/trans-filling room upon observation by the Maintenance Director. This finding was reviewed with the Executive Director at the time of exit. 3.1-19(b)		will audit areas in the facility to secure any oxygen cylinders not appropriately stored. Nursing staff educated on o2 cylinder storage. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Maintenance Director/ designee, will audit random facility care areas 3 times a week x 2 months then, 2 times a week for 2 months then 2 times monthly for the duration of 6 months Any negative trends will be reviewed in the monthly QAPI program. Any concerns will be monitored through the QAPI process for a minimum of six months and until 95% compliance is achieved.	