STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155384	A. BUILDING -- B. WING	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LINCOLN HILLS CARE CENTER	402 19TH STREET TELL CITY, IN 47586

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 05/13/2024 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.473. Survey Date: 07/10/2024 Facility Number: 000411 Provider Number: 155703 AIM Number: 201274720 At this Post Survey Revisit, Brickyard Healthcare-Lincoln Hills 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 a capacity of 86 certified beds and had a census of 66 at the time of this visit. Quality Review completed on 07/18/24	E 0000	Preparation and submission of this plan of correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible. The facility would like to respectfully request a paper compliance. Thank you.	
K 0000 Bldg. 01	A Post Survey Resvisit (PSR) to the survey which exited on 05/13/2024 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100 At this Life Safety Code survey, Brickyard Healthcare-Lincoln Hills Care Center was found	K 0000	Preparation and submission of this plan of correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Pennington	Executive Director	07/31/2024

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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	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 with a lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 66 at the time of this survey. Quality Review completed on 07/18/24		submission of a Plan of Correction as a condition to participate in Title 18 and 19 programs, and to provide the best possible care to our residents as possible. The facility would like to respectfully request a paper compliance. Thank you.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure 1 of 1 battery backup lights were tested monthly over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner	K 0291	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The battery backup light has been tested. The Maintenance Director will maintain monthly testing of the battery backup lights with a record of visual inspections. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective	08/12/2024

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	for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: During record review on 07/10/2024 between 11:45 AM and 2:47 PM local time with the Interim Director of Maintenance, there was no documentation regarding monthly battery operated emergency light testing during May or June 2024 for 1 of 1 battery operated emergency lights. Based on interview at the time of record review, the Director of Maintenance was not aware of any additional documentation of the battery operated emergency lights testing anywhere else in the building. This finding was reviewed with the Interim Director of Maintenance and the Executive Director at the exit conference. This deficient practice was cited on 05/13/2024. The facility failed to implement proper corrective action. 3.1-19(b)		action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any resident in this area may be affected by this practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? A monthly 30 second functional test inspection and record of visual inspections will be completed. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity the findings of the visual inspections and tests in the Quality Assurance Process Improvement meeting.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the assistant administrator office each month. NFPA 10, Standard for Portable Fire Extinguishers,	K 0355	What corrective action will be accomplished for those residents found to have been affected by this deficient practice. The fire	08/12/2024

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	Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self-expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect residents, staff, and visitors in the areas. Findings include: Based on observation during a tour of the facility with the Interim Director of Maintenance on		extinguisher in the assistant administrator office has been removed. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. All residents in this area have the potential to be affected by this practice. What measures and systemic changes will be made to ensure the deficient practice does not recur? The fire extinguisher in the assistant administrator office has been removed. Monthly inspections of the fire extinguishers will be completed and logged in the TELS system. How will the corrective action be monitored? The Maintenance Director will report the results of the inspection no less than quarterly in perpetuity in the Quality Assurance Process Improvement meeting.	

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	07/10/2024 between 11:45 AM and 2:47 PM local time, the monthly inspection tag on the fire extinguisher in the assistant administrator office had a tag which indicated it was last inspected in September of 2023. Based on interview at the time of observations, the Interim Director of Maintenance stated he was unaware of the fire extinguisher in the aforementioned location. This finding was reviewed with the Executive Director and Interim Director of Maintenance at the exit conference. This deficient practice was cited on 05/13/2024. The facility failed to implement proper corrective action. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers located in the assistant administrator's office was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that			

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	indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect staff. Findings include: Based on observation during a tour of the facility with the Interim Director of Maintenance on 07/10/2024 between 11:45 AM and 2:47 PM local time, the fire extinguisher in the assistant administrator's office had a tag which indicated the last annual inspection date was March 2023. Based on interview at the time of observation, the Interim Director of Maintenance acknowledged the fire extinguisher in the assistant administrator's office was past due for the annual inspection. This finding was reviewed with the Executive Director and Interim Director of Maintenance at the exit conference. This deficient practice was cited on 05/13/2024. The facility failed to implement proper corrective action. 3.1-19(b)			
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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.			

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	Based on observation and interview, the facility failed to ensure 5 of 5 boilers had current inspection certificates to ensure the boilers were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff, and visitors. Findings include: Based on observation during a tour of the facility with the Interim Director of Maintenance on 07/10/2024 between 11:45 AM and 2:47 PM local time, the following five boilers had expired or missing Certificate of Inspection documentation from the State of Indiana: a. the service boiler identified as IN0333304 had a Certificate of Inspection stating the expiration date was 05/12/2024. b. the service boiler identified as IN0337950 had a Certificate of Inspection stating the expiration date was 05/12/2024. c. the service boiler identified as IN0355341 had a Certificate of Inspection stating the expiration date was 05/12/2024. d. the service boiler identified as IN0355342 had a Certificate of Inspection stating the expiration date was 05/12/2024. e. the service boiler identified as IN0308090 had a Certificate of Inspection stating the expiration date was 05/12/2024. Based on interview at the time of record review, the Executive Director stated the inspection has been completed, but they do not have the paperwork This finding was reviewed with the Executive	K 0500	What corrective action will be accomplished for those residents found to have been affected by this deficient practice? The boiler inspections have been completed. How will other residents having the potential to be affected by this same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Any residents in this area have the potential to be affected by this practice. The boiler inspections have been completed. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? An inspection of the boiler water heaters and confirmed state inspections will be completed in the TELS system every 12 months. How will the corrective action be monitored to ensure the deficient practice will not recur? The Maintenance Director will report no less than quarterly in perpetuity the results of the inspections in the Quality Assurance Performance Improvement meeting.	10/09/2024

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	Director and the Interim Director of Maintenance at the exit conference. This deficient practice was cited on 05/13/2024. The facility failed to implement proper corrective action. 3.1-19(b)		The boiler inspection is complete. All boilers passed inspection. The inspections have been forwarded to the state boiler division. The permits have not been posted in the state boiler division website. A waiver has been filed, based on waiting on the state to post the permit.	