STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING -- B. WING	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MERRILLVILLE CARE CENTER	8800 VIRGINIA PLACE MERRILLVILLE, IN 46410

(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: 07/3/24 Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660 At this Emergency Preparedness survey, Brickyard Healthcare - Merrillville 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 164 certified beds. At the time of the survey, the census was 145. Quality Review completed on 07/08/24	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: 07/3/24 Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660 At this Life Safety Code survey, Brickyard Healthcare - Merrillville Care Center was found not in compliance with Requirements for	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline Carpenter-Heard	Executive Director	07/24/2024

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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	155362	A. BUILDING 01 B. WING	07/03/2024

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	Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are provided with battery powered smoked detectors. The facility is fully protected by a 400-kW diesel generator. The facility has the capacity for 164 and had a census of 145 at the time of this survey. Quality Review completed on 07/08/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall 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,			

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	155362	A. BUILDING 01 B. WING	07/03/2024

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	19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 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			

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	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 1 of 3 egress doors on the C-wing with delayed egress, was equipped as required by LSC 7.2. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect up to 26 residents, as well as staff and visitors in the Northwest corridor of the C-wing. Findings include: Based on observation during a tour of the facility with the Executive Director and Maintenance Director on 07/03/24 at 11:20 a.m., the exit door from the Northwest corridor of the C-wing was provided with delayed egress but lacked the proper signage indicating the door can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Executive Director and Maintenance Director acknowledged the egress door was equipped with a delayed egress and lacked the proper signage. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0222	K 222 Egress doors Exit door on C Wing was provided with delayed egress but lacked the proper signage indicating the door can be opened in 15 seconds by pushing the door. The exit door immediately had the alarm code posted over the alarm box for all to know how to exit door if needed and the 15 second delayed egress signage was put on the door that it can be opened in 15 seconds by pushing the door. Others All people in the building can be affected by this alleged deficient practice. All exit doors were checked, and no other exit doors were deficient. Education The ED/designee educated the maintenance staff on Egress Doors policy. Monitor The ED/designee will audit all Exit doors with alarms with delayed egress 3 times a week x one month, then weekly x 1 month, then monthly to ensure all doors are not safety hazards.	07/29/2024

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			The ED/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. Date of compliance 7/29/2024	
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 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 observation and interview; the facility failed to ensure battery-operated smoke alarms in offices and other ancillary areas were maintained. NFPA 101 in 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, Section 29.10 states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. Section 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. Section 14.4.8.1 states unless otherwise recommended by the	K 0300	K 300 Protection - Other The facility failed to ensure battery operated smoke alarms in offices and other ancillary areas were manufactured within 10 years. All smoke alarms were checked, and the detectors in non-resident rooms were removed. Others All can be affected by the alleged deficient practice. Education The	07/29/2024

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	manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 07/03/24 at 11:48 a.m. the facility failed to ensure battery-operated smoke alarms in offices and other ancillary areas were manufactured within the past 10 years. Based on observation, interview and record review, battery-operated smoke alarms in resident rooms had been maintained according to manufacturer's published instructions; however, battery-operated smoke detectors in non-resident rooms had not been maintained. When the Maintenance Director was asked the date of manufacture of the smoke detector in the dining room on the C-wing, he stated it was more than 10 years old. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		ED/designee educated the maintenance staff on Smoke alarm policy. Monitor The Maintenance Director/designee will maintain a monthly battery-operated smoke detector log of resident rooms and monitor in TELS also. This will be done with a one-time audit of all non-resident room areas. The ED/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. Date of compliance 7/29/2024	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material			

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	capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors on the C-wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of	K 0363	K 363 Corridor - Doors The facility failed to ensure 1 of over 30 corridor doors on C-wing were provided with a	07/29/2024

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	smoke. This deficient practice could affect up to 64 residents, as well as staff and visitors in the C-wing. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 07/03/24 at 12:08 p.m., the corridor door to a linen storage closet on the C-wing next to room 228 was unable to latch into the frame. Based on observation the latch hole in the door frame was stuffed with paper and had tape applied over the hole, preventing the door from properly latching. Based on interview with the Maintenance Director at the time of observation, he acknowledged the corridor door was unable to latch and then removed the impediment allowing the door to latch properly. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		means suitable for keeping the door closed, had no impediment to closing, latching and resist the passage of smoke. The impediment was immediately removed, and the doorknob type changed. Others Up to 64 residents as well as staff and visitors in the C-wing Education Then Maintenance Department was educated on the Corridors Safety policy. Monitor The Maintenance director/designee will perform a monthly door latch check in TELS. Audits will include audits by the DNS/designee will audit the corridor/linen doors weekly X 2 months then monthly for 6 months. The ED/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. Date of compliance 7/29/2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment			

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	complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical light switch outlets in the Assistant Dietary Manager office was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff in the kitchen. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 07/03/24 at 1:26 p.m., the light switch cover in the Assistant Dietary Manager office was missing. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that exposed wiring was visible. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0511	K 511 Utilities – Gas and Electric The facility failed to ensure 1 of 1 electrical light switch outlets in the Assistant Dietary Manager office was protected, the light switch cover was missing. Then light switch cover was changed immediately. Others Other areas could be affected by this alleged deficient practice. Education The maintenance Director was educated on monitoring electrical covers. Monitor Then maintenance director/designee will audit electrical outlets monthly and put a monthly general check in TELS The ED/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. Date of compliance 7/29/2024	07/29/2024

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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 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 cord 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 cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect up to 64 residents, as well as staff and visitors in the Northeast wing.	K 0920	K 920 Electrical Equipment – Power Cords and Externs A power strip was found powering a high-amperage refrigerator in resident room 329 on the Northeast wing. The refrigerator was immediately plugged into the wall socket. Others Other rooms with	07/29/2024

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	Findings include: Based on observation during a tour of the facility with the Executive Director and Maintenance Director on 07/03/24 at 1:03 p.m., a power strip was found powering a high-amperage refrigerator in resident room 329 in the Northeast wing. Based on interview with the Maintenance Director at the time of observation, he acknowledged the use of a power strip to supply power to a refrigerator. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		refrigerators have the potential to be affected by the deficient practice. Education All staff were educated on the Electrical equipment policy. Monitor A full facility audit will be completed, and this will be recorded and continued monthly in TELS The ED/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue. Date of compliance 7/29/2024	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) 1.) Based on observation and interview, the facility failed to ensure 1 of 3 oxygen storage	K 0927	K 927 Gas Equipment – Transfilling Cylinders	07/29/2024

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	rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99, Health Care Facilities, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 64 residents, as well as staff and visitors in the C-wing. Findings include: Based on observation during a tour of the facility with the Executive Director and Maintenance Director on 07/03/24 at 11:33 a.m., there was a mechanically ventilated exhaust fan in the ceiling of the oxygen storage/transfilling room on C-wing; however, it was not working at the time of observation. This was acknowledged by the Maintenance Director at the time of observation. 2.) Based on observation and interview, the facility failed to ensure 1 of 3 oxygen storage/transfer locations was used properly and in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect up to 64 residents, as well as staff and visitors in the C-wing. Findings include: Based on observation during a tour of the facility with the Executive Director and Maintenance Director on 07/03/24 at 11:33 a.m., the oxygen		There was a mechanically ventilated exhaust fan in the ceiling of the oxygen/transfilling room on C-wing that was not working. Also, the facility failed to ensure 1 of 3 oxygen/transfer locations was used properly. The ventilation was fixed in the Oxygen storage room and a lock was placed on the breaker that controls the O2 room exhaust. Others 64 residents as well as staff and visitors could be affected on the C-wing Education All licensed nursing and therapy were educated, and the employee was immediately educated on the Oxygen use policy, including keeping the door closed during transfilling. Maintenance was educated on the O2 requirements policy in storage rooms. Monitor A monthly inspection for O2 storage and a signage check are in TELS. Inspection for all rooms to be followed. The ED will audit monthly for 6 months. The ED/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audits will continue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 01 B. WING	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MERRILLVILLE CARE CENTER	8800 VIRGINIA PLACE MERRILLVILLE, IN 46410

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	storage/transfer room on the C-wing of the facility was used by a therapy employee. The employee entered the oxygen transfilling room, held the door open with her body, and placed the portable oxygen unit on the oxygen tank, and began to transfer oxygen from the main tank to the portable oxygen tank while she was holding the door to the corridor open. At the time of the observation, the Executive Director discussed this with the therapy employee who stated she had recently started and did not know to not hold the door open. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Date of compliance 7/29/2024	