| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155686 | A. BUILDING -- B. WING | 07/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - KNOX CARE CENTER | 300 E CULVER RD KNOX, IN 46534 |

| (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<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 07/24/24<br><br>Facility Number: 000088<br>Provider Number: 155686<br>AIM Number: 100289260<br><br>At this Emergency Preparedness survey, Brickyard Healthcare - Knox Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 57 certified beds. At the time of the survey, the census was 53.<br><br>Quality Review completed on 07/26/24 | E 0000 | Plan of Correction Text:<br>Preparation, submission and implementation of this Plan of Correction is prepared and executed continually improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in the survey.<br><br>Respectfully<br>Submitted, Jerrell Harville, HFA | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jerrell Harville | Executive Director | 08/05/2024 |

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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|---|---|---|---|
| | 155686 | A. BUILDING 01<br>B. WING | 07/24/2024 |

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| BRICKYARD HEALTHCARE - KNOX CARE CENTER | 300 E CULVER RD<br>KNOX, IN 46534 |

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| K 0000<br><br>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).<br><br>Survey Date: 07/24/24<br><br>Facility Number: 000088<br>Provider Number: 155686<br>AIM Number: 100289260<br><br>At this Life Safety Code survey, Brickyard Healthcare - Knox 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.<br><br>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a monitored fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms contained battery-operated smoke detectors. The facility has a capacity of 57 and had a census of 53 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review completed on 07/26/24 | K 0000 | Plan of Correction Text:<br>Preparation, submission and implementation of this Plan of Correction is prepared and executed continually improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in the survey.<br><br>Respectfully<br>Submitted, Jerrell Harville, HFA | |

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| K 0211<br>SS=E<br>Bldg. 01 | NFPA 101<br>Means of Egress - General<br>Means of Egress - General<br>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.<br>18.2.1, 19.2.1, 7.1.10.1<br>Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:<br>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).<br>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.<br>(c)The wheeled equipment is limited to the following:<br>i. Equipment in use and carts in use<br>ii. Medical emergency equipment not in use<br>iii. Patient lift and transport equipment<br>This deficient practice affects approximately 15 residents and staff.<br><br>Findings include:<br><br>Based on an observation during a tour of the facility with the Maintenance Director 07/24/24 between 10:56 a.m. and 11:52 a.m., one Personal Protective Equipment (PPE) cart was in use, outside of room 34, but was not equipped with | K 0211 | 1. No residents were identified as being affected by this deficiency. Identified cart was replaced by a wheeled cart.<br>2. All residents are potentially affected by this alleged deficiency. All items identified were replaced to meet regulatory guidelines.<br>3. Maintenance director will monitor hallways/egresses weekly for inspection compliance. And monthly thereafter to ensure continued compliance. Any concerns will be addressed at time of discovery.<br>4. Maintenance director will present his weekly audits x 1 month, and his monthly audits x 6 months to the Quality Assurance Performance Improvement Meeting.<br>5. Identified deficiencies will be rectified by<br>__8/11/24_____. | 08/11/2024 |

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| | wheels allowing the cart to be moved out of the hall during an emergency. Based on an interview at the time of observation, the Maintenance Director stated the PPE cart was not equipped with wheels and would need to be replaced with a PPE cart with wheels. He further stated that the PPE carts are supposed to be placed within the rooms if possible, so he was unsure why it was in the hallway.<br><br>The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0363<br>SS=D<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>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 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 | | | |

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| | 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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>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 30 resident room corridor doors in the facility were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 4 residents and staff.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 07/24/24 between 10:54 a.m. and 11:52 a.m., the corridor door to resident room 12 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director acknowledged the door would not latch into the frame and would take care of the issue.<br><br>The finding was reviewed with the Administrator and the Maintenance Director during the exit | K 0363 | 1. No residents were identified as being directly affected by this deficiency. Door closure for identified room, Room 12, has been adjusted by maintenance director to close and latch per regulations.<br>2. All Residents are potentially affected by this deficient practice. Door closures for resident rooms have been reviewed by maintenance director to close and latch per regulations.<br>3. Maintenance director will audit all doors to ensure compliance weekly x 4 weeks, then monthly x 6 months. Any deficiencies will be fixed at time of identification.<br>4. Maintenance director will present findings of his audits monthly x 6 months to the Quality | 08/11/2024 |

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| | conference.<br><br>3.1-19(b) | | Assurance Performance Improvement.<br>5. Identified deficiencies will be rectified by<br>__8/11/24_____ | |