STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING -- B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

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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: 08/10/23 Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130 At this Emergency Preparedness survey, Brickyard Healthcare - Elkhart Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 175 certified beds. At the time of the survey, the census was 95. Quality Review completed on 08/14/23	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

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

Chad Knisley | Executive Director | 08/28/2023

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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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/10/23 between 09:27 a.m. and 11:27 a.m., the generator lacked monthly load testing and weekly visual inspections required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The findings were reviewed with the Maintenance Director at the exit conference.	E 0041	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that load testing and a visual inspection was done immediately in order to ensure that no residents were affected. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 95 residents. The Maintenance Director, or designee, conducted a load test and visual inspection in order to meet LSC and NFPA 110. The Maintenance Director, or designee, completed education with all staff to ensure that they understood the policy regarding monthly load testing of the generator and weekly visual testing. **3. Measures put into place/ system changes.** This alleged deficient practice had the potential to affect 92 residents. The Maintenance Director, or designee, conducted a	09/15/2023

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			load test and visual inspection in order to meet LSC and NFPA 110. The Maintenance Director, or designee, completed education with all staff to ensure that they understood the policy regarding monthly load testing of the generator and weekly visual testing. The Maintenance Director, or designee, will complete a load test monthly for 6 months and then monthly moving forward and will complete a visual inspection weekly for 6 months and then weekly moving forward. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will complete a load test monthly for 6 months and then monthly moving forward and will complete a visual inspection weekly for 6 months and then weekly moving forward. The findings of the observations will be recorded and discussed in the facilities QAPI process as well as in the TELS program. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	
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).	K 0000	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient**	

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	Survey Dates: 08/10/23 Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130 At this Life Safety Code survey, Brickyard Healthcare - Elkhart 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 (000) construction and was fully sprinklered except for the electrical room in the maintenance shop. The original building (North, East and South Units) was constructed in 1968 with an addition (Primrose and Southwest Units) built in 1975. The North Unit has been decommissioned and no longer has residents. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility is protected by a full-building 500 kW diesel generator. The facility has a capacity of 175. The census at the time of this survey was 95. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered with the exception of the electrical room in the maintenance shop. Quality Review completed on 08/14/23		**practices.** The Maintenance Director, or designee, ensured that no residents have access to the electrical room in the maintenance shop due to lock and key and that it is sprinklered. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 0 residents as this is not a resident area. The Maintenance Director, or designee, conducted an audit of all non-resident areas in order to ensure that they are sprinkled. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that All areas of the building must be sprinklered. **3. Measures put into place/ system changes.** This alleged deficient practice had the potential to affect 0 residents as this is not a resident area. The Maintenance Director, or designee, conducted an audit of all non-resident areas in order to ensure that they are sprinkled. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that All areas of the building must be sprinklered. The Maintenance Director, or	

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			designee, will audit all non-resident areas daily for weekly for 4 weeks and monthly for 5 months in order to ensure that they are sprinklered. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will audit all non-resident areas weekly for 4 weeks and monthly for 5 months in order to ensure that they are sprinklered. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	
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.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 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			

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	on door assemblies in buildings protected 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 the means of egress through 3 of 5 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. LSC 7.2.1.5.3 requires if provided, locks shall not require of a key, a tool, or special knowledge or effort for operation from the egress side This deficient practice could affect approximately 15 residents and staff in 200-wing.. Findings include: Based on observation with the Maintenance Director on 08/10/23 between 12:15 p.m. and 2:50 p.m., the exit doors listed as doors #5,#7, and #8 in 200-wing were marked as a facility exit, were magnetically locked, and could be opened by entering a five-digit code on the access panel. There was a message stating the code to the door is accessed by following certain steps. There were approximately 10 different colored circles identified. Each color corresponded with certain words on the posted message and the code had to be deciphered from the color that was marked with an "X". When the code was able to be found, the code did not unlock the doors on all three of the exit doors. Based on interview at the time of observation, the Maintenance Director stated that	K 0222	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that doors 5, 7, and 8's codes were changed and that the correct codes were posted. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 15 residents. The Maintenance Director, or designee, conducted an audit all facility exit doors in order to ensure that the posted codes were correct and allowed exit. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that the exit doors codes were to be posted and correct. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit all facility exit doors in order to	09/15/2023

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	facility staff have a general code for the exit doors that did work, however that code was not the code posted at the aforementioned areas. The findings were reviewed with Maintenance Director during the exit conference. 3.1-19(b)		ensure that the posted codes were correct and allowed exit. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that the exit doors codes were to be posted and correct. The Maintenance Director, or designee, will audit all facility exit doors daily for weekly for 4 weeks and Monthly for 5 months to ensure that all posted codes are correct. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will audit all facility exit doors weekly for 4 weeks and Monthly for 5 months to ensure that all posted codes are correct. The findings of the audits will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	
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.)			

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	Based on observation and interview, the facility failed to ensure 1 of 4 exit signs were continuously illuminated in North Wing. This deficient practice could affect approximately 3 staff and an unknown number of residents. Findings include: Based on observations on 08/10/23 during a tour of the facility from 11:27 a.m. to 2:50 p.m. with the Maintenance Director, the North Wing exit sign above the exit door leading to the main dining area was not illuminated. Based on an interview with the Maintenance Director at the time of observation, it was stated the exit sign light bulbs are burned out. Findings were discussed with the Maintenance Director at exit conference. 3.1.19(b)	K 0293	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that the North Wing exit sign above the exit door leading to the main dining area was illuminated. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 3 staff. The Maintenance Director, or designee, conducted an audit of all facility exit signs to ensure that they were illuminated. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all exit signs must be illuminated. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of all facility exit signs to ensure that they were illuminated. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all exit signs must be illuminated. The Maintenance Director, or designee, will observe all exit signs weekly for 4 weeks	09/15/2023

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			and monthly for 5 months in order to ensure that they are properly illuminated. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will observe all exit signs weekly for 4 weeks and monthly for 5 months in order to ensure that they are properly illuminated. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC	K 0341	**1. What corrective actions will be accomplished for those residents found to have been**	09/15/2023

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	9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 10.4.2 requires that devices and appliances shall be located and mounted so that accidental operation or failure is not caused by vibration or jarring. This deficiency could affect approximately 4 staff in the kitchen and 15 residents who use the adjacent dining room. Findings include: Based on record review with the Maintenance Director on 08/10/23 between 12:15 p.m. and 2:50 p.m., the hardwired heat detector located in the center of the dish washer area of the kitchen was originally mounted, but fell and was dangling by wires. At interview upon observation, the Maintenance Director confirmed the issue and agreed that the heat detector was dangling. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		**affected by the deficient practices.** The Maintenance Director, or designee, ensured the hardwired heat detector located in the center of the dish washer area of the kitchen properly mounted to the wall. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 15 residents. The Maintenance Director, or designee, conducted an audit of all fire alarm systems to ensure that they were secured in place properly. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all fire alarm systems should be secured in place. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of all fire alarm systems to ensure that they were secured in place properly. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all fire alarm systems should be secured in place. The Maintenance Director, or designee, will observe	

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			all fire alarm systems weekly for 4 weeks and Monthly for 5 months to ensure that they are secured in place. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will observe all fire alarm systems weekly for 4 weeks and Monthly for 5 months to ensure that they are secured in place. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	
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 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			

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	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 4 of 54 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 12 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 08/10/23 between 12:15 p.m. and 2:50 p.m., the following corridor doors were either unable to latch or had difficulty latching into place: a) Resident room 206, 313, and 209 were unable to latch	K 0363	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that Resident room doors 206, 313, 209 and 208 closed and latched into place. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 12	09/15/2023

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	b) Resident room 208 had difficulty latching after testing twice Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned deficiencies and stated that the latching hardware for the doors will need to be adjusted. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		residents. The Maintenance Director, or designee, conducted an audit of all corridor doors in order to ensure that they close and latch into place. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all corridor doors must close and latch into place. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of all corridor doors in order to ensure that they close and latch into place. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all corridor doors must close and latch into place. The Maintenance Director, or designee, will audit all corridor doors weekly for 4 weeks and Monthly for 5 months to ensure they close and latch into place. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will audit all corridor doors weekly for 4 weeks and Monthly for 5 months to ensure they close and latch into place. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September,	

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			2023.	
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 conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 08/10/23 at 10:02 a.m., the following shifts were missing documentation of a completed fire drill: a) A third and second shift fire drill in the first quarter of 2023. b) A third and second shift fire drill in the second quarter of 2023. Based on interview at the time of record review, both Maintenance Directors agreed that the documentation for the missing fire drills could not	K 0712	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, completed fire drills on 3rd and 2nd shift. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 95 residents. The Maintenance Director, or designee, conducted an audit of all fire drills in order to ensure that they were complete. The Maintenance Director, or designee, completed education with all staff to ensure that they	09/15/2023

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	be found during record review. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b) 3.1-51(c)		understood that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of all fire drills in order to ensure that they were complete. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The Maintenance Director, or designee, will audit fire drill completion weekly for 4 weeks and Monthly moving forward to ensure that they are held at expected and unexpected times, under varying conditions, at least quarterly on each shift. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will audit fire drill completion weekly for 4 weeks and Monthly moving forward to ensure that they are held at expected and unexpected times, under varying conditions, at least quarterly on each shift. The findings of the observations will be recorded and discussed in the facilities QAPI process as well as the TELS system. **5. Date of compliance.**	

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			Brickyard of Elkhart alleges compliance on 15 September, 2023.	
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 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.			

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	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 maintain a complete written record of monthly generator load testing for 2 of 12 months and weekly inspection for 11 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 08/10/23 between 09:21 a.m. and 11:27 a.m., no documentation was available for the months of November and October of 2022 to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Documentation provided at the survey showed that the task was closed but stated that "old items with no data". The tasks did not list and document required variables when doing a monthly load test. Furthermore, weekly generator inspections were missing for the months of October and November of 2022, plus three out of four weeks in September of 2022. Based on	K 0918	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that the generator set in service was exercised for a minimum of 30 minutes and that variables were listed and documented when completing the load test and that the weekly generator inspection was completed. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 95 residents. The Maintenance Director, or designee, conducted an audit of all generator load testing documents in order to ensure that it was complete. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that the generator is to be set in service and exercised at least once monthly for 30 minutes and must be inspected weekly. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of	09/15/2023

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	interview at the time of record review, the Maintenance Director stated that he was unaware if the inspections were completed and the only place that had the inspections would be in the online program which was incomplete. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise 1 of 1 generators annually 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 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 (Load Bank Test) 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 occupants. Findings include:		all generator load testing documents in order to ensure that it was complete. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that the generator is to be set in service and exercised at least once monthly for 30 minutes and must be inspected weekly. The Maintenance Director, or designee, will ensure that the generator is set in service and exercised for a minimum of 30 minutes and that variables are listed and documented when completing the load test Monthly for 6 months and that the weekly generator inspection is completed weekly moving forward to ensure that the generator is functioning properly. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will ensure that the generator is set in service and exercised for a minimum of 30 minutes and that variables are listed and documented when completing the load test Monthly for 5 months and that the weekly generator inspection is completed weekly moving forward to ensure that the generator is functioning properly. The findings of the observations will be recorded and discussed in the facilities QAPI process as well as in the TELS system.	

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	Based on records review with the Maintenance Director on 08/10/23 between 09:21 a.m. and 11:27 a.m., two months of monthly load testing were unavailable for review to determine if the generator ran over 30% load for every month of the last 12 months. Monthly load testing that was available stated the emergency generator ran at 30% load. Also, the available load bank test for review had a date 05-23-23. However, the documentation for the load bank listed a numerical value of "0" for every box of the load which indicated a load bank test wasn't complete. Based on interview at the time of record review, the Maintenance Director stated the generator ran under load on monthly but did not know if the load achieve 30 % of the generator's name plate rating for every month. Additionally, the Maintenance Director acknowledged a load bank test for the generator was documented, but it was an incomplete record and could not fully determine if a load bank was even conducted. At the time of record review, the generator service company was able to be contacted and further clarified that a load bank test was not done due to a deficiency with the generator. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure the continuing reliability and integrity of 1 of 1 emergency generators. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 08/10/23 between 09:21 a.m. and 11:27		**5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	

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	a.m., a letter from the contracted service company for the generator stated the "automatic Transfer Switch (ATS) will not transfer building load automatically". An invoice provided stated that parts were on order and in the process of getting supplies to complete the repairs. The letter obtained from the service company states the generator is operable and able to supply emergency power as needed. During interview with the Maintenance Director, they stated they were aware of the issue and stated that the generator works and supplies power, but does not automatically transfer power and further said the facility is waiting for the contractor to come out and complete the repairs. The finding was reviewed with the Maintenance Director during the exit conference. 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			

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	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 2 of 2 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 approximately 4 staff and residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/10/23 between 12:15 p.m. and 2:50 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Nursing Managers office and resident room 504. Based on interview at the time of observation, the Maintenance Director acknowledged the power strips in both rooms and removed the power strip in the Nursing Managers office. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)	K 0920	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that the refrigerator in the Nursing Managers office and in resident room 504 were relocated, plugged into a standard wall outlet and that the power strips were removed. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 4 residents. The Maintenance Director, or designee, conducted an audit of the building in order to ensure that high power draw equipment was plugged into standard wall outlets. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all high power draw equipment must be plugged into a standard wall	09/15/2023

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			outlet. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of the building in order to ensure that high power draw equipment was plugged into standard wall outlets. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that all high power draw equipment must be plugged into a standard wall outlet. The Maintenance Director, or designee, will audit all areas weekly for 4 weeks and Monthly for 5 months to ensure that all high power draw equipment is plugged into standard wall outlets. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will audit all areas weekly for 4 weeks and Monthly for 5 months to ensure that all high power draw equipment is plugged into standard wall outlets. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	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) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location had proper separation 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 approximately 20 residents and staff in the Southwest Wing nurses station smoke compartment. Findings include: Based on observation with the Maintenance Director during observation at 11:06 a.m. on 08/10/23 the oxygen storage/transfer room on the Southwest wing of the facility was used by a female employee. The employee was observed in the oxygen transfilling room, holding the door open with her leg, and placed the portable oxygen unit on the oxygen tank, and was transfilling oxygen from the main tank to the portable oxygen tank while she was holding the door to the corridor open. Based on interview at the time of the observation, the employee was asked if this	K 0927	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practices.** The Maintenance Director, or designee, ensured that the oxygen storage/transfer room on the Southwest wing of the facility's light was replaced and that the door was closed while staff were transfilling oxygen. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** This alleged deficient practice had the potential to affect 20 residents. The Maintenance Director, or designee, conducted an audit of all oxygen storage/transfilling rooms in order to ensure that they had functioning lighting and that the door was closed while staff were transfilling	09/15/2023

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	155685	A. BUILDING 01 B. WING	08/10/2023

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	was the normal procedure for transferring oxygen to a portable oxygen tank, and she stated it is not and she wasn't able to see because the light isn't working. When interviewing the Maintenance Director, he acknowledged that the employee held the door open while transfilling. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)		oxygen. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that the door to the oxygen storage/transfer rooms must remain closed while they are transfilling oxygen. **3. Measures put into place/ system changes.** The Maintenance Director, or designee, conducted an audit of all oxygen storage/transfilling rooms in order to ensure that they had functioning lighting and that the door was closed while staff were transfilling oxygen. The Maintenance Director, or designee, completed education with all staff to ensure that they understood that the door to the oxygen storage/transfer rooms must remain closed while they are transfilling oxygen. The Maintenance Director, or designee, will audit all oxygen storage/transfilling rooms weekly for 4 weeks and Monthly for 5 months to ensure that the door to the oxygen storage/transfer rooms must remain closed while they are transfilling oxygen. **4. How the corrective actions will be monitored.** The Maintenance Director, or designee, will audit all oxygen storage/transfilling rooms weekly for 4 weeks and Monthly for 5 months to ensure that the door to the oxygen storage/transfer rooms must remain closed while they are	

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			transfilling oxygen. The findings of the observations will be recorded and discussed in the facilities QAPI process. **5. Date of compliance.** Brickyard of Elkhart alleges compliance on 15 September, 2023.	