STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING -- B. WING	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(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: 08/06/2024 Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310 At this Emergency Preparedness survey, Brickyard Healthcare - Fountainview 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 130 certified beds. All beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 76. Quality Review completed on 08/07/24	E 0000	This response is not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The facility respectfully requests paper compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(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), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Morgan	Executive Director	08/20/2024

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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	implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(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), §485.542(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),§485.542(e)(2) 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), REHs at §485.542(g), and and CAHs §485.625(g):]			

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	155178	A. BUILDING -- B. WING	08/06/2024

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	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 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			

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	155178	A. BUILDING -- B. WING	08/06/2024

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	30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record 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 record review with the Administrator and Director of Maintenance on 08/06/24 between 09:31 a.m. and 11:30 a.m., the generator lacked documentation of a fuel analysis within the past twelve months. Based on interview at the time of record review, the Director of Maintenance acknowledged the lack of documentation and further stated that he was waiting for the results and the sample has been pulled. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	E041 Hospital CAH and LTC Emergency Power • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. Fuel analysis was completed, and record of the passing test is on file. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential of being affected by the deficient practice. Fuel analysis was completed, and record of the passing test is on file. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director and Maintenance Assistant were re-educated on the requirements of having a generator fuel analysis being done at least every 12	08/26/2024

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			months with documentation on file. TELS Maintenance System is triggered for 6/1/25 for Maintenance Director to initiate/schedule another fuel analysis. Also there is a calendar invite in place for both the Maintenance Director and the Executive Director for 6/1/25 to ensure another analysis is scheduled within 12 months of the latest analysis. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Required and completed Monthly Maintenance tasks scheduled through the TELS system will be reviewed monthly at the facility QAPI meetings for the next 12 months.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/06/2024 Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310	K 0000	This response is not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The facility respectfully requests paper	

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			compliance.	
	At this Life Safety Code survey, Brickyard Healthcare - Fountainview 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. This one story facility with partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The building is partially protected by a 350 kW diesel-powered generator. The facility has a capacity of 130 beds dually certified for Medicare and Medicaid and had a census of 76 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the maintenance shed used for storage. Quality Review completed on 08/07/24			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 7.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 3 of over 30 sprinkler heads in the B wing were free of paint accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 30 residents and staff. Findings include: Based on observation with the Maintenance Director and Administrator on 08/06/24 between 11:42 a.m. and 1:33 p.m., resident room 214 had a closet which contained a pendant type sprinkler head. The sprinkler head had noticeable paint on the deflector and frame. Furthermore, the "B" wing nurses station had two pendant type sprinkler heads. Both sprinkler heads also had paint on the frames of the heads. Based on interview at the time of observation, the Maintenance Director acknowledged the paint and further stated that a painter hired by the facility redid resident rooms	K 0353	K353 – Sprinkler System – Maintenance and Testing • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the deficient practice. Three sprinkler heads noted to have paint on them are scheduled to be replaced on 8/26/24. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents on the wings that had the noted sprinkler heads have the potential to be affected by the deficient practice. All three of the sprinkler heads noted to have paint on them are scheduled to be replaced on 8/26/24. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director and	08/26/2024

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	and areas within the wing which must have gotten paint on the sprinkler heads. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		Maintenance Assistant were re-educated on the requirement of sprinkler heads needing to be free of corrosion, foreign materials, paint, and physical damage. Maintenance Director or designee will check sprinkler heads quarterly to ensure no paint, corrosion, or foreign material is present. Checks will be recorded in TELS quarterly. SafeCare is also contracted for quarterly inspections of sprinkler heads. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and TELS reports with quarterly tasks will be reviewed each month in QAPI meetings for the next 6 months.	
K 0363 SS=D 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			

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	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 1 resident lounge corridor door on the 200 wing was 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 6 residents and staff. .	K 0363	K363 – Corridor - Doors • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this deficit practice. The loose latch	08/26/2024

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	Findings include: Based on observation with the Maintenance Director on 08/06/24 between 11:42 a.m. and 1:33 p.m., the resident lounge across from resident room 228 had no smoke detection, had a set of double corridor doors with latching hardware. When tested, the inactive door would not latch into the frame after testing three times. Based on interview at the time of observation, the Maintenance Director confirmed that the door did not latch and further stated that the latching device at the top of the door was loose and would not properly operate. The latch was adjusted and able to latch by the end of the survey. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		was adjusted, and the door was latching properly by the end of the survey, as noted in the Life Safety Inspector report. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents and staff in that corridor had the potential to be affected by the deficient practice. The loose latch was adjusted, and the door was latching properly by the end of the survey, as noted in the Life Safety Inspector report. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director and Maintenance Assistant were re-educated on the requirement of all corridor doors or doors to rooms containing flammable or combustible materials needing to have positive latching hardware. Maintenance Director or designee will check doors quarterly to ensure all are latching appropriately. Checks will be recorded in TELS quarterly. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and TELS reports with quarterly tasks	

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			will be reviewed each month in QAPI meetings for the next 6 months.	
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			

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	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents and staff. Findings include: Based on record review with the Administrator and the Maintenance Director on 08/06/24 between 09:31 p.m. and 11:30 a.m., no documentation of an annual fuel quality test for the diesel generator within the past 12 months was available for review. The last documentated fuel sample analysis was dated April of 2023. A generator inspection report dated 07/18/24 indicated that a fuel sample was drawn and sent into the lab for testing. Based on interview at the time of record review, the Maintenance Director acknowledged that the fuel sample results had not been received as of the survey and is just awaiting results from the lab. The Maintenance Director was able to contact the company which stated the sample has not been processed at the date of the survey. This finding was reviewed with the Administrator	K 0918	K918 – Electrical Systems – Essential Electrical System Maintenance and Testing • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. Fuel analysis was completed, and record of the passing test is on file. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential of being affected by the deficient practice. Fuel analysis was completed, and record of the passing test is on file. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director and Maintenance Assistant were re-educated on the requirements of having a generator fuel analysis being done at least every 12 months with documentation on file. TELS Maintenance System is triggered for 6/1/25 for Maintenance Director to initiate/schedule another fuel	08/26/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(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
	and Maintenance Director at the exit conference. 3.1-19(b)		analysis. Also there is a calendar invite is in place for both the Maintenance Director and the Executive Director for 6/1/25 to ensure another analysis is scheduled within 12 months of the latest analysis. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Required and completed Monthly Maintenance tasks scheduled through the TELS system will be reviewed monthly at the facility QAPI meetings for the next 12 months.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 01 B. WING	08/06/2024

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	(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 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 approximately 2 staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/06/24 between 11:47 a.m. and 1:33 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the medical records office. Based on interview at the time of observation, the Maintenance Director confirmed that the fridge was supplied power by a power strip. The fridge was unplugged at the time of observation. The finding was reviewed with the Maintenance Director at exit conference. 3.1-19(b)	K 0920	K920 – Electrical Equipment – Power Cords and Extension Cords • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents or staff were affected by the alleged deficient practice. The power strip was removed, and the refrigerator was plugged directly into the wall for power. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; It was noted that two staff had the potential of being affected by the deficient practice. The power strip was removed, and the refrigerator was plugged directly into the wall for power. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance	08/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 01 B. WING	08/06/2024

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			Director/Maintenance Assistant and all managers were re-educated on the requirements of not using power strips as a substitute for fixed wiring to provide power to equipment with high current draw, specifically refrigerators. Maintenance Director or Maintenance Assistant will check all offices monthly to ensure no refrigerators or high current draw items are plugged into power strips in staff offices. This will be logged and tracked monthly through the TELS system. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Required and completed Monthly Maintenance tasks scheduled through the TELS system will be reviewed monthly at the facility QAPI meetings for the next 12 months.	