STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155076	A. BUILDING -- B. WING	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER	7145 E 21ST STREET INDIANAPOLIS, IN 46219

(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: 01/16/25 Facility Number: 000031 Provider Number: 155076 AIM Number: 100266150 At this Emergency Preparedness survey, Brickyard Healthcare -Brookview 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 136 certified beds. At the time of the survey, the census was 74. Quality Review completed on 01/21/25	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: 01/16/25 Facility Number: 000031 Provider Number: 155076 AIM Number: 100266150 At this Life Safety Code survey, Brickyard	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia Aldridge	Executive Director	02/03/2025

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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	Healthcare-Brookview 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 facility, with the east and west wing consisting of one story and the subacute wing consisting of two stories and a basement, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. All resident sleeping rooms were surveyed. The facility has a capacity of 136 and had a census of 74 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage services which was not sprinklered. Quality Review completed on 01/21/25			
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 13 hazardous areas such as fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0321	The two separate 8-inch diameter holes were repaired. All residents in the smoke compartment above have potential to be affected by this alleged deficient practice. A penetration task was placed in TELS to check for and repair any penetrations found at an inspection schedule of every 6 months. Maintenance will report to	01/30/2025

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	Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 01/16/25, two separate eight inch in diameter holes were noted in the ceiling of the natural gas fired boiler room in the basement which exposed the interstitial space above the ceiling in the room. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)		QAPI no less than quarterly in perpetuity on life safety issues. Date of completion was 1/30/25.	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchens in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 2 kitchen staff. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 01/16/25, one of one ceiling mounted sprinkler locations in the shelf storage area for meal trays in the kitchen had a missing escutcheon which exposed the attic	K 0351	The ceiling mounted sprinkler escutcheon in the shelf storage area for meal trays was replaced. This alleged deficient practice has potential to affect all residents. An in-house sprinkler inspection was added to TELS which includes checking for escutcheons being in place every month. Maintenance will report to QAPI no less than quarterly in perpetuity on life safety issues.	01/30/2025

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	above. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned sprinkler location was missing its escutcheon. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview; the facility failed to ensure proper operation was maintained for 1 of 1 rolling steel fire doors in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room. Findings include:	K 0761	The “mouse trap” or “firefly” mechanism was replaced to ensure the roll down fire door releases with the fire alarm system as required. This alleged deficiency could affect all residents in the same smoke compartment. A monthly task has been added to TELS to test the roll down fire door during the monthly fire drill, repair if needed, and reset and restore to service. Maintenance will report to QAPI no less than quarterly in perpetuity on life safety issues.	01/30/2025

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	Based on review of the rolling fire door inspection contractor's "Doors: Roll Door Inspection" documentation dated 06/07/24 with the Director of Maintenance during record review from 10:00 a.m. to 12:20 p.m. on 01/16/25, the rolling fire door in the kitchen was listed as "Fail" for the result of each of the two drop tests conducted on 06/07/24 inspection and testing. The "Comments" section of the 06/07/24 inspection report stated "reset tension but the actuation does not work". Review of the rolling fire door inspection contractor's "Work Performed" documentation dated 06/10/24 stated "upon arriving took apart the wiring on the kitchen roll door release mechanism. To find that the mouse trap and rbsn (?) is working correctly. Tested the system by setting off the alarm and the door dropped the first time but did not release the second time. The mouse trap release seems to be working when it wants to and not all the time. Suggest that we install a new door release box and he will need a quote before going ahead and saying yes". Based on interview at the time of record review, the Director of Maintenance stated repair or replace documentation on or after 06/07/24 for the rolling fire door was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 01/16/25, the metal rolling fire door between the kitchen and main Dining Room was in the closed position and was equipped with a 3-hour fire resistance rating label affixed to the door. No contractor documentation on or after 06/07/24 was affixed to the door. The Dining Room was open to the corridor. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.			

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	3.1-19(b)			
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Central Supply Office by resident Room 201. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 01/16/25, an operating electric portable space heater was plugged into an extension cord on the floor of the Central Supply Office near Room 201. Manufacturer's documentation affixed to the portable space heater did not state the operating temperature achieved by the portable space heater. Based on interview at the time of the observations, the Director of Maintenance agreed a portable space heater was in use in the Central Supply Office. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference.	K 0781	The portable space heater in the central supply office was removed. All residents in the adjacent smoke compartment have potential to be affected by this alleged deficient practice. A monthly task was added to TELS for space heaters which states Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius), and to not plug them into power strips, multiplug adapters or extension cords. Maintenance will report to QAPI no less than quarterly in perpetuity on life safety issues.	01/30/2025
	3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to document emergency generator monthly load testing for 3 months of the most	K 0918	The maintenance director was trained how to document the run under load tests correctly and to	01/30/2025

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	recent 12 month period 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 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 residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator Under Load" documentation for the most recent twelve month period with the Director of Maintenance during record review from 10:00 a.m. to 12:20 p.m. on 01/16/25, monthly load testing documentation for the facility's diesel fired emergency generator on 09/27/24, 10/01/24 and on 11/20/24 did not state the generator was run under load for a minimum of 30 minutes. The "Run time" on the three reports was listed as, respectively, 5 minutes, 5 seconds and 10 minutes.		place appropriate 30 or more minutes of run time in the documentation in the proper area as well as the proper minimum 5 minute cool down time being placed in the appropriate area. All residents have potential to be affected by this alleged deficient practice. A monthly TELS inspection is in place which outlines where to document the data. Maintenance will report to QAPI no less than quarterly in QAPI on life safety issues.	

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	Based on interview at the time of record review, the Director of Maintenance stated he started working at the facility about one year ago, the generator is run under load for a minimum of 30 minutes but agreed monthly load testing documentation for the aforementioned three month period was not documented correctly. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test for 6 of 12 months. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.4 which requires emergency generators providing power to emergency lighting systems to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 6.2.10 Time Delay on Engine Shutdown requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown to allow for engine cooldown. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. NFPA 110, Section 8.3.4 states a permanent record of the Emergency Power Supply Systems (EPSS) inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and visitors. Findings include:			

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	Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator Under Load" documentation for the most recent twelve month period with the Director of Maintenance during record review from 10:00 a.m. to 12:20 p.m. on 01/16/25, monthly load testing documentation for the facility's diesel fired emergency generator for 6 months of the most recent 12 month period did not include the cool down time for a minimum of 5 minutes. The "Cool Down" time listed on monthly load tests on 01/31/24, 02/12/24, 04/17/24, 05/31/24, 07/31/24 and on 10/01/24 was listed as, respectively, 2 minutes, 2 minutes, 2 minutes, 2 minutes, 2 minutes and the time of day as 14:37. Based on interview at the time of record review, the Director of Maintenance stated he started working at the facility about one year ago, the generator is run under load for a minimum of 30 minutes with a cool down time of at least 5 minutes but agreed the cool down time for monthly load testing documentation for the aforementioned six months was not documented correctly. Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 01/16/25, manufacturer's nameplate information affixed to the emergency generator indicated it was rated at 350 kW. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure multiplug adaptors and extension	K 0920	The space heater and extension cord were removed from central	01/30/2025

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	cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:40 p.m. to 2:55 p.m. on 01/16/25, the following was noted: a. an operating electric portable space heater was plugged into an extension cord on the floor of the Central Supply Office near Room 201.		supply. The electrical devices were plugged directly into the wall in room 423 and the multiplug adapter removed. This alleged deficient practice could potentially affect all residents in the adjacent areas. A Monthly check was added to TELS for the space heater issue and a monthly task was added to TELS on the use of extension cords, power strips, and multiplug adapters. Maintenance will report to QAPI no less than quarterly in perpetuity.	

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	b. an Enteral Feeding Pump, an air mattress and the resident bed were plugged into a multiplug adaptor plugged into a receptacle in the wall mounted outlet box at the head of the resident bed nearest the window in resident sleeping Room 423. Based on interview at the time of the observations, the Director of Maintenance agreed an extension cord and a multiplug adaptor were being used as a substitute for fixed wiring in the aforementioned two locations in the facility. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			