STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155136	A. BUILDING -- B. WING	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE LA PORTE, IN 46350

(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: 02/09/23 Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620 At this Emergency Preparedness survey, Brickyard Healthcare - Terrace 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 a capacity of 176 and had a census of 117 at the time of this survey. Quality Review completed on 02/13/23	E 0000	**Brickyard Terrace Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** Brickyard Terrace Care Center kindly requests consideration of a desk review.	
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: 02/09/2023 Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620 At this Life Safety Code survey, Brickyard Healthcare - Terrace Care Center was found not in compliance with Requirements for Participation in	K 0000	**Brickyard Terrace Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** Brickyard Terrace Care Center kindly requests consideration of a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Shepperd	Executive Director	02/24/2023

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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	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. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors with battery operated smoke detectors in the resident sleeping rooms. The building is protected by a 55 kW natural gas powered generator which provided emergency power. The facility has 176 beds dually certified for Medicare and Medicaid and had a census of 117 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 garage and storage shed. Quality Review completed on 02/13/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of	K 0211	**K211 Means of Egress** **What corrective action(s) will be accomplished for those**	02/20/2023

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	fire or other emergency. This deficient practice could affect at least 4 residents and staff in the corridor near room #4. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and Administrator on 02/09/23 between 12:18 p.m. and 3:07 p.m., the exit corridor near resident room #4 contained a recliner stored in hall. Based on an interview at the time of observations, the Maintenance Director agreed there was non-care items stored in the corridor and removed it upon observation. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice?** · Recliner near room #4 removed no ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All current residents have the potential to be affected by this alleged deficient practice. Audit completed of all hallways to ensure there were no obstructions in other corridors. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · All staff were educated on means of egress and corridors remaining free from all obstructions in case of emergencies/fire. · Maintenance Director/Designee will audit hallways 5x a week x 6 months to ensure hallways are free from obstructions. · All audits will include all units. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place? · The Maintenance Director/designee will complete audit tool to eliminate the potential for any corridor obstructions · The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms			

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	b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 8 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 15 residents or staff in one smoke compartment Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 02/09/23 between 12:18 p.m. and 3:07 p.m., the Janitor Closet next to the time clock station had more than 15 cardboard boxes of paper towel and housekeeping supplies and was greater than 50 square feet. When testing the door, the door did not self-close. Based on interview at the time of observation, the Maintenance Director agreed the room was a hazardous storage area, and the door to the room was not self-closing. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b	K 0321	**K321 Hazardous Areas** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Self-closing device placed in the janitor closet next to the timeclock station. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All current residents have the potential to be affected by this alleged deficient practice. Audit completed of all hazardous storage areas to ensure that all of the other doors had a self-closing device. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · Maintenance Director was	02/20/2023

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			educated on hazardous areas requiring a self-closing swing arm. · Maintenance Director/Designee will audit hazardous storage areas quarterly x 6 months to ensure doors self-closing swing arms are fully functional. · Audits will include all units. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Maintenance Director/designee will complete audit tool to ensure that hazardous storage closets have self-closing devices attached to the door. · The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.			

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	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 3 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect at least 2 staff. Findings include: Based on observation with the Administrator and Maintenance Director on 02/09/23 between 12:18 p.m. and 3:07 p.m., when the GFCI electric receptacle next to the sink in the activities office was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0511	**K511** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · GFCI (Ground fault circuit interrupter) in Activities office was replaced. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All current residents have the potential to be affected by this alleged deficient practice. Audit completed of all GFCI's in house to ensure that they're all in working condition. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · Maintenance Director was educated that all areas in the building that require GFCI's are to be in working condition. · Maintenance Director/Designee will audit random GFCI's within the building monthly x 6 months to ensure they're in working condition. · Audits will include all units. **How will the corrective**	02/20/2023

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			action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The Maintenance Director/Designee will complete audit tool to ensure that areas of the building that contain GFCI receptacles are functioning properly. · The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.			

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	(3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 1 of 1 facility areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Director and Administrator on 02/09/23 between 12:18 p.m. and 3:07 p.m., in the area of the kitchen emergency exit door there were over 12 cigarette butts disposed on the ground in and around the area. Also, when asked about smoking policy, the facility stated they are a non-smoking facility and have no designated areas. Based on interview at the time of observations, the Administrator agree there were cigarette butts on the ground in the aforementioned location. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0741	**K741** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All cigarette butts located outside the kitchen exit were disposed of in a noncombustible container. No ill effect noted due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All current staff have the potential to be affected by this alleged deficient practice. Audit completed of all exit door areas to ensure that no other cigarette butts were improperly disposed of. **What measures will be put into place or what systemic changes will you make to**	02/20/2023

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			ensure that the deficient practice does not recur? · All staff was educated on the facility being a non-smoking property and proper disposal of cigarettes. · Maintenance Director/Designee will audit 5 exit door areas 5x a week x 6 months to ensure that there are no cigarette butts. · Audits will include all units. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Maintenance Director/designee will complete audit tool to ensure that exit doors remain free from cigarette butts. · The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
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			

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	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. 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 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 02/09/23 between 09:22 a.m. and 12:17 p.m., the Generator Maintenance Report from	K 0918	**K918 Electrical Systems** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Technicians came out to service generator on 2/17/2023. No ill effect due to alleged	02/20/2023

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	03/31/22 stated the emergency generator needed a coolant flush, replace hoses, thermostat, and radiator cap for preventative maintenance. Generator report states the generator is operable at time of maintenance. Furthermore, the report states that: "Valve covers are leaking some oil. When other repairs are done need to replace valve cover gaskets as well. Voltage adjusting reostat is bad you have to adjust voltage at the regulator adjusting pot, needs replaced." During interview with the Maintenance Director, they stated they were aware of the report and stated the generator was going to be repaired when the next servicing is done. Repairs had not been completed at the time of the survey. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All current residents have the potential to be affected by this alleged deficient practice. Service completed on generator to ensure that all recommended maintenance took place timely. Weekly audits to occur to ensure generator is in optimal functioning order. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · Maintenance Director was educated on service recommendations by the technician taking place timely on facility's generator. · Maintenance Director/Designee will audit generator weekly x 6 months to ensure that generator is functioning properly, and timely services are completed as needed. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Maintenance	

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			Director/designee will complete audit tool to ensure that generator maintenance is maintained weekly. · The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.			

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BRICKYARD HEALTHCARE - TERRACE CARE CENTER	1900 ANDREW AVE LA PORTE, IN 46350

(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
	10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. 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 12 staff Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 02/09/23 between 12:18 p.m. and 3:07 p.m., the following deficiencies were noted: a) Schedulers office contained a power strip plugged into an extension cord powering appliances b) Business office contained a power strip plugged into an extension cord powering appliances c) The conference room contained an extension cord powering appliances. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the use of extension cords and power strips. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0920	**K930 Electrical Equipment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Extension cord removed from scheduler's office. No ill effect due to alleged deficient practice · Extension cord removed from BOM's office. No ill effect due to alleged deficient practice · Extension cord removed from the conference room. No ill effect due to alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All current residents/staff have the potential to be affected by this alleged deficient practice. Audit completed of all office areas to ensure that there were no extension cords/power cords being utilized. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · All staff was educated on	02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING 01 B. WING	02/09/2023

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			the prohibition of extension/power cord use in offices. · Maintenance Director/Designee will audit 5 office areas 5x a week x 6 months to ensure there are no extension/power cords being utilized. · Audits will include all shifts. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Maintenance Director/designee will complete audit tool to ensure that extension/power cords are not being utilized in office areas. · The Maintenance Director/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	